HCFA Information
Resource Center

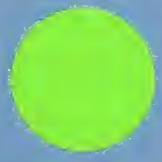
Health Care Financing

Grants and Contracts Report

National Hospital Rate-Setting Study, Vol. VII

Case Study of Prospective Reimbursement in New York

PUBS
RA
971
.3
N38
1980
v.7



Published by Health Care Financing Administration

E
S.8

Health Care Financing Grants and Contracts Reports

Health Care Financing Grants and Contracts Reports are published periodically by the Health Care Financing Administration's Office of Research, Demonstrations, and Statistics.

The Health Care Financing Administration was established in March 1977 to combine HEW's health financing and quality assurance programs into a single agency. HCFA is responsible for the operation of the Medicare and Medicaid programs, the PSRO program, Federal survey and certification efforts, and a variety of health care quality assurance activities.

The mission of the Health Care Financing Administration is to promote the timely delivery of appropriate, quality health care to its beneficiaries—approximately 45 million aged, disabled, and poor Americans. HCFA is committed to making beneficiaries aware of the services for which they are eligible, promoting the accessibility of those services and ensuring that HCFA policies and actions promote efficiency and quality within the total health care delivery system.

HCFA's Office of Research, Demonstrations, and Statistics (ORDS) conducts studies and projects that demonstrate and evaluate optional reimbursement, coverage, eligibility, and management alternatives to the present Federal programs. ORDS also assesses the impact of HCFA programs on health care costs, program expenditures, beneficiary access to services, health care providers, and the health care industry. In addition, ORDS monitors national health care expenditures and prices and provides actuarial analyses on the costs of current HCFA programs as well as the impact of possible legislative or administrative changes in the programs.

ORDS also annually conducts over 200 intramural and extramural research, demonstration, and evaluation projects. The Health Care Financing ***Grants and Contracts Reports*** series presents the final reports from selected ORDS/HCFA-funded extramural projects.

QA
971.3
.N38
1980
v.7
c.3

Health Care Financing Grants and Contracts Report

Case Study of Prospective Reimbursement in New York

This report was made pursuant to contract No. 500-78-0036 between Health Care Financing Administration and Abt Associates Incorporated, Cambridge, Massachusetts; Policy Analysis, Incorporated, Brookline, Massachusetts, subcontractor.

Craig Coelen, Project Director
Marilyn Falik, HCFA Project Officer
Authors: Diane E. Hamilton
Gilbey Kamens

Published by HEW
Health Care Financing Administration
Office of Research, Demonstrations,
and Statistics
April 1980

NEW YORK

Since the inception of the program in 1970, the Department of Health has been responsible for prospective reimbursement in New York. The Department determines procedural regulations, sets rates and hears appeals for hospital reimbursement by Medicaid. The Downstate Blue Cross plan and a consortium of the Upstate plans set rates for Blue Cross patients, but the Department of Health must approve both the procedures used and the actual rates set by the Blue Cross programs. Since 1978 the annual inflation allowance developed by the Department for Medicaid rate setting has been used as a ceiling on percentage increases in the rates paid by charge-based payors. Thus, only rates for Medicare patients are not set, approved or limited by the policies and procedures of the Department of Health.

The procedures used to set rates for both Blue Cross and Medicaid are very similar and very mechanical. Nonallowable costs are excluded from base-year expenditures. Peer group comparisons are used to exclude routine and ancillary costs above group averages. Automatic penalties are imposed on hospitals with unacceptably low occupancy rates or unacceptably long average lengths of stay. Adjusted base-year cost is inflated by the projected increase in input prices. Over time, the disallowances and penalties imposed by both the Medicaid and Blue Cross programs have become more stringent.

Since the per diem rates set by the New York programs are used by both Medicaid and Blue Cross for reimbursement, enforcement is not an issue in New York. The large volume of appeals by hospitals has increased the administrative cost of the program. By the beginning of 1978 a backlog of 2400 appeals had accumulated. New procedures were instituted for appeals, and most of the backlog had been eliminated by the start of 1979.

ACKNOWLEDGMENTS

The authors would like to acknowledge that information for this case study was provided through personal and telephone interviews, correspondence and secondary data supplied by many people. A list of these people is included in Appendix A of this report.

The authors would like to especially acknowledge the following people for the generous amount of time and effort they contributed to our knowledge.

Mr. Jack Herbst
Director
Bureau of Economic Analysis

Mr. Bill McCann
Executive Director
Council on Health Care Financing

Mr. Charles Miller
Partner
Covington and Burling

Mr. Lou Orsini
Vice President and Director
Consumer and Professional
Relations Division
Health Insurance Association
of America

Mr. Stan Peck
Associate Director
Health Insurance Association
of America

Mr. Bob Reed
Administrative Services Group
New York State Department of Health

Dr. John Rossman
Director of Health Economics
Hospital Association of New York State

Mr. Phil Valenti
Senior Analyst Provider Reimbursement
Blue Cross of Northeastern New York, Inc.

Mr. John Zampier
Director of Provider Reimbursement
Blue Cross of Northeastern New York, Inc.

In addition, the authors would like to thank Mary Schumacher, and earlier Kim Lanzillotti, for their editing assistance in this final product. Extensive thanks go to Sharon Snyder for coordination of the site visits, copy editing, management of production and most importantly, formatting of text and tables. Last, but certainly not least, thanks go to Valerie Simpkins, who assisted in the typing and production of this report.

Also, the authors express sincere appreciation to HCFA staff for their technical assistance, especially to prior project officers, Fred Hellinger, Ruth Lis, Arne Anderson, and Bruce Steinhardt.

TABLE OF CONTENTS

Foreword	vii
INTRODUCTION	1
General Scope and Summary of the New York State Prospective Reimbursement System	1
Comparative Trends in New York Hospitals	2
ADOPTION	5
Pressures Leading to Adoption	5
Subsequent Fiscal Pressures and New Legislation	8
CONTENT AND PROCESS	9
Organization	9
Timing	12
Process	14
Allowable Costs	14
Grouping Mechanisms	14
The Trend Factor	16
Formula and Disallowances	20
The Medicaid Formula	20
The Upstate Blue Cross Formula	22
The Downstate Blue Cross System	23
Special Programs	25
The Emergency Reimbursement Program	25
The Hospital Closure Incentive Program	27
The Hospital Conversion Incentive Program	27
Data Required	27
Appeals and Litigation	28
Appeals	28
Litigation	31
Program Cost	36

TABLE OF CONTENTS
(continued)

Developmental Efforts 38

Incorporation of Case-Mix Considerations into the Appeals Program 38

Budget Review 39

The Northeastern New York Blue Cross Hospital Experimental Reimbursement Study 39

The Crouse-Irving Memorial Hospital Experiment 39

The Minicap Program 39

The Maxicap Program 39

INTERACTIONS 40

Legislature 40

Hospital Association of New York State 40

Planning 43

Unions 50

Health Insurance Association of America 54

PROGRAM RIGOR, INCENTIVES AND EQUITY 55

Program Rigor 55

Structure 55

Process 56

Reaction of Regulatees 58

System Incentives 58

System Equity 61

Extent of Due Process 61

Ambiguity in Rate Setting 61

Arbitrariness in the Rate-Setting System 61

Uncertainty in the Rate-Setting System 62

Equity in Interhospital Comparisons 62

Extent of Cross-Subsidization 62

APPENDIX A 63

LIST OF TABLES

1	Differences in Medicaid and Blue Cross Groupings	15
2	Variables Used in Cluster Analysis	16
3	Sources of Wage Price Movements in New York State Trend Factor	19
4	Formula Content and Changes Over Time for Medicaid and Upstate and Downstate Blue Cross	26
5	Rate-Setting Personnel and Expenses, Fiscal Years 1971 to 1978	37
6	Relative Strength of System Incentives by Year	60

LIST OF FIGURES

1	Comparison of Hospital Indicators: Capacity, Volume of Service and Utilization for Community Hospitals, 1969-1977 - New York vs. U.S.	3
2	Comparison of Hospital Indicators: Expense, Total Revenue and Assets for Community Hospitals, 1969-1977 - New York vs. U.S.	4
3	Location of Rate-Setting Body Within State Department of Health	10
4	Ideal Time-Line for Rate-Setting Process	13
5	Relationship Between Planning and Office of Health Systems Management	45
6	Flowchart of New York State's Certificate of Need Process	46

FOREWORD

The following case study report of prospective reimbursement in New York has been written as part of the National Hospital Rate-Setting Study. This study is being conducted for the Office of Research, Demonstrations, and Statistics of the Health Care Financing Administration, U.S. Department of Health, Education, and Welfare, by Abt Associates Inc., Policy Analysis, Inc., and Health Economics Research, Inc.* The overall goal of the three-year study is to determine the impact of rate setting on hospital costs, quality of hospital care, and access to health care by the elderly and the economically disadvantaged. In addition, the study will examine the impact of prospective reimbursement on other areas of hospital performance, including revenues, volume and composition of services, productivity, wages, case mix, and administrative behavior. Because the effects of prospective reimbursement may be felt beyond the hospital sector, the study will also examine impacts on the costs and utilization of the health care system as a whole.

This volume is one of nine case study reports (Arizona, Connecticut, Maryland, Massachusetts, Minnesota, New Jersey, New York, Washington, and Western Pennsylvania). Each report examines in detail the adoption, implementation, review processes and legal challenges of each prospective reimbursement system. In addition, the reports examine linkages and interactions that take place between rate-setting agencies and other organizations such as planning groups, hospital associations, third party payors, and unions. Each case study also presents a preliminary analysis of the potential rigor and equity of the prospective reimbursement system. (A separate report, A Comparative Analysis of Nine Prospective Reimbursement Programs, analyzes all nine programs simultaneously along these factors.) The case study reports will be most useful to those interested in a detailed description of the prospective reimbursement programs in the nine states under study.

The preliminary analyses of rigor and equity in the case studies are interim in nature. Data collection on hospital performance is still ongoing and will yield important information about the effectiveness of administrative structures and procedures in containing costs and delivering quality service. Final results of the study are expected in 1982.

Diane E. Hamilton
Deputy Project Director &
Director of Case Studies
National Hospital
Rate-Setting Study

---

*Arthur D. Little, Inc. and Arthur Andersen & Co. are also participating in the National Hospital Rate-Setting Study but were not involved in the case studies.

INTRODUCTION

General Scope and Summary of the New York State Prospective Reimbursement System

The prospective reimbursement (PR) program in New York is a mandatory, formulistic system which has been in operation since January 1, 1970. Until 1977, the program covered Medicaid and Blue Cross patients. In 1978, essentially all payors (except Medicare) were covered since, at that time, rate increases to charge-paying payors could increase by no more than the allowable trend factor established by the state.[1]

Those health institutions that are subject to prospective rate setting regulations in the state of New York include:

- any hospital (in the generic sense of the word) with an operating certificate;
- any skilled nursing facility (SNF) or intermediate care facility (ICF) that is licensed to operate by the New York State Department of Health;
- any licensed free-standing treatment or diagnostic center or clinic; and
- home health agencies.

The prospective reimbursement formula in New York has varied over time, as well as among Medicaid, the Upstate Blue Cross plans and the Downstate Blue Cross plan. This introductory discussion concentrates solely on the 1978 Medicaid formula, since the current differences between the Medicaid and Blue Cross formulas are minor. The discussion, therefore, should prove useful for a general understanding of the New York system.

The prospective reimbursement formula establishes a per diem rate based on actual costs incurred in a given base year, which is two years prior to the year the rate goes into effect. Routine costs for each hospital--after adjusting for geographic differences in wages--are compared with those of other hospitals of the same type in terms of size, teaching status, ownership, service mix and other product-differentiating characteristics. This type of comparison is also made of ancillary costs; any routine or ancillary costs in excess of 100 percent of the peer group average are considered excessive and are automatically disallowed. In addition, ten percent of intern and resident salaries are automatically disallowed. After eliminating disallowed costs, routine and ancillary costs are added together and adjusted for inflation in input prices estimated to

[1] Workmen's Compensation and No Fault Insurance, which reimburse on a more liberal formula basis, are covered payors.

occur between the base year and the rate year. Nonoperating (capital) costs are then added to routine and ancillary costs to arrive at the total allowable costs for the rate year.

Once total costs for the rate year have been projected, they are divided by the number of patient days in the base year to calculate a per diem rate. However, if the hospital has not maintained certain occupancy minimums as required by the formula, its patient days are increased to meet the occupancy criteria. Increasing the denominator of the formula in this way decreases the resultant per diem rate.

In addition, the hospital is screened for average length of stay. Each hospital's length of stay is compared to its peer group average plus one-half day. Any excess days over this minimum are multiplied by the hospital's discharges to arrive at the total patient days attributable to excess length of stay. These total patient days are then multiplied by the lower of the routine per diem ceiling for the group or the hospital's routine per diem to arrive at a total dollar disallowance for excessive length of stay.

In summary, the prospective reimbursement formula in New York uses base-year costs to project rate-year costs, disallowing ten percent of intern and resident salaries. A hospital is penalized if (1) its routine costs, ancillary costs or length of stay are excessive in relation to hospitals of similar type, and if (2) it fails to maintain certain required occupancy minimums.

The following section presents some significant characteristics and trends in the New York hospital industry as compared to national data. These trends serve as a useful introduction to the hospital industry in the New York system.

Comparative Trends in New York Hospitals

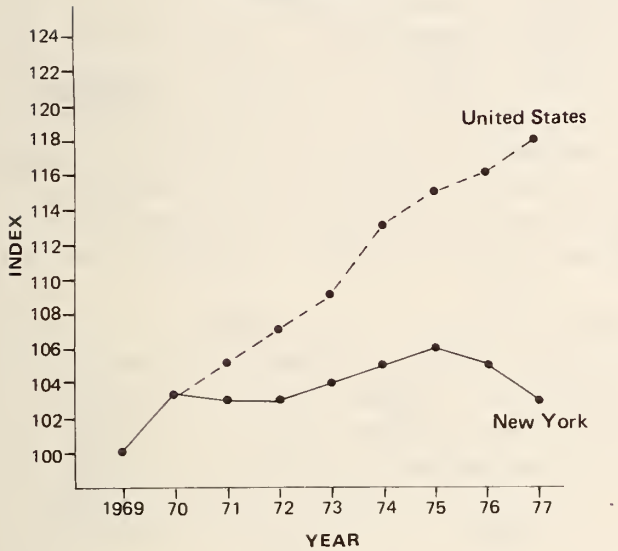
Longitudinal trends and comparisons between the state and the nation have been examined for the following variables: total number of beds, total patient days, occupancy, length of stay, expense per patient day, revenue per patient day, assets per bed, and expense per capita (see Figures 1 and 2).

In general, both beds and patient days have increased at a slower rate in New York than nationally; length of stay in New York has remained fairly constant, while it has slightly decreased nationally. Finally, while absolute levels of expense and revenue per patient day, assets per bed, and expense per capita are generally higher in New York than nationally, the rates of increase in New York have paralleled those of the nation, with a few exceptions--the years 1970 and 1976. While 1970 was the prospective reimbursement (PR) adoption year in New York and 1976 was the year in which the formula was made substantially more constraining, the trends in the

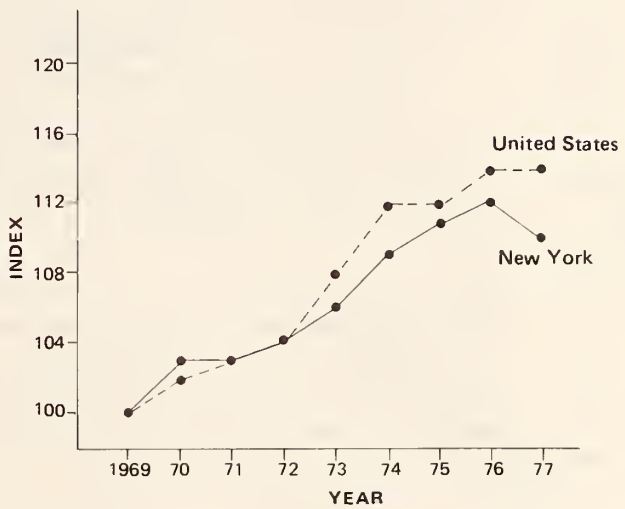
Figure 1

COMPARISON OF HOSPITAL INDICATORS:
Capacity, Volume of Service and Utilization
for Community Hospitals, 1969-1977
NEW YORK vs. U.S.

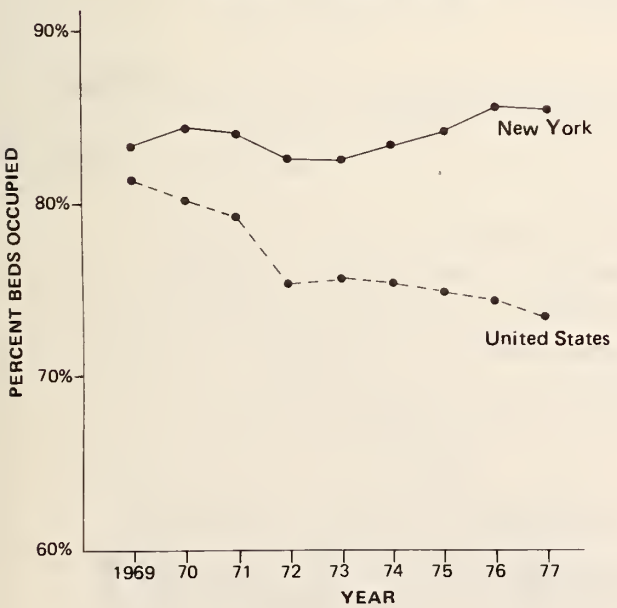
INDEX OF TOTAL BEDS
(1969 = 100.0)



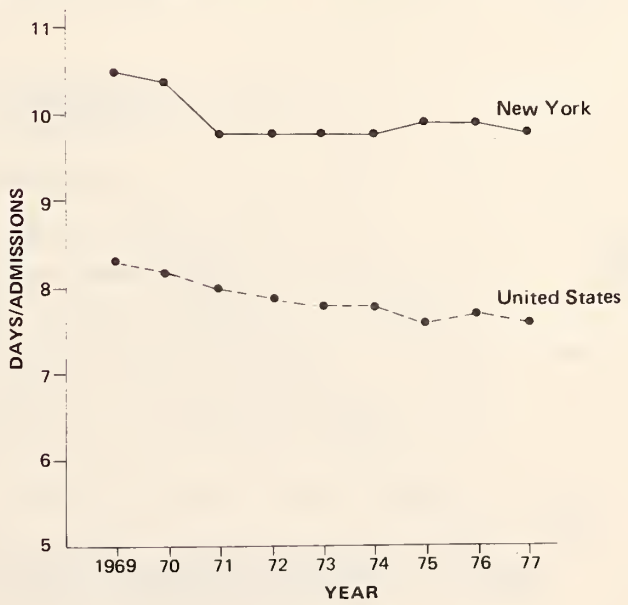
INDEX OF ADJUSTED PATIENT DAYS
(1969 = 100.0)



AVERAGE OCCUPANCY RATES



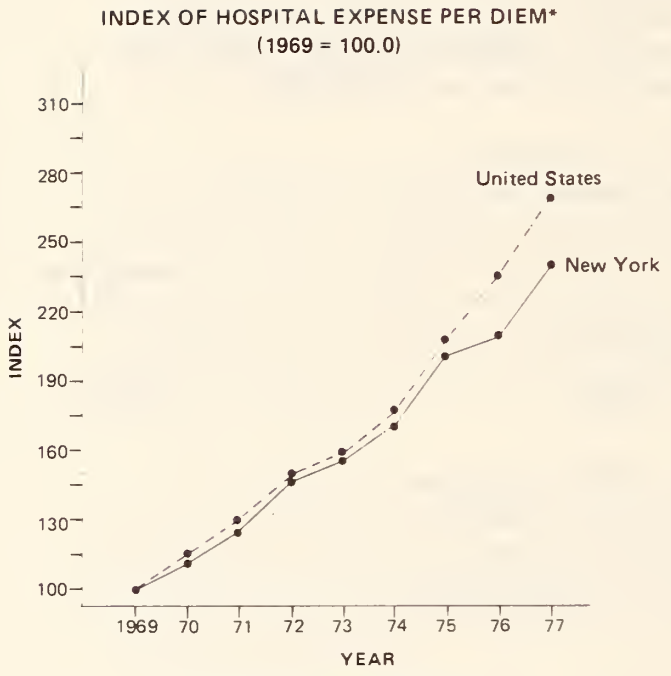
AVERAGE LENGTH OF STAY

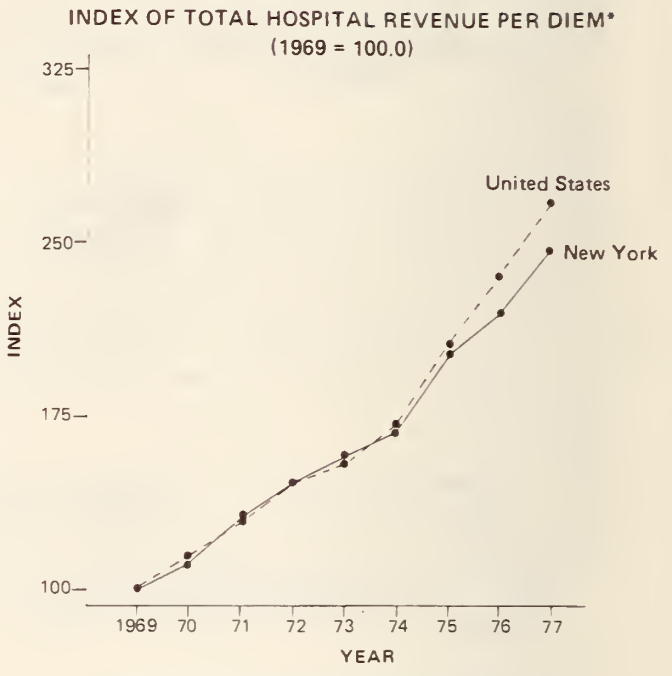


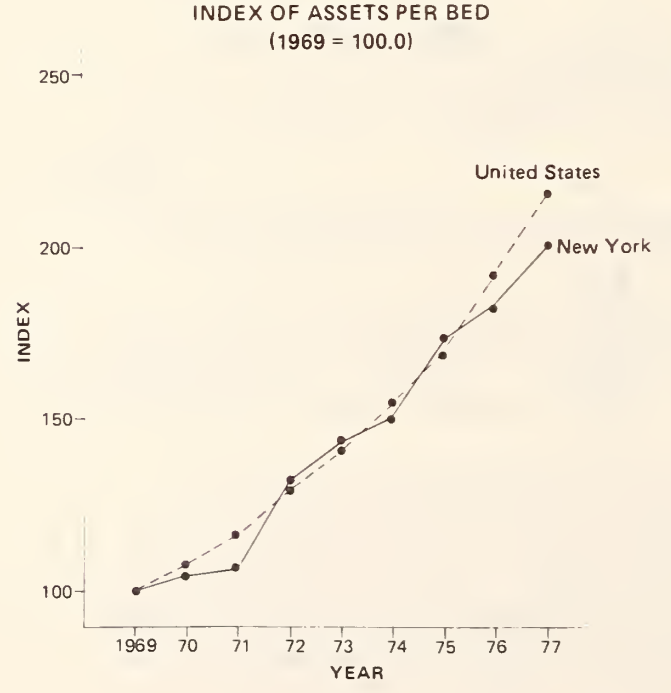
Sources: U.S. Bureau of the Census
American Hospital Association, *Hospital Statistics*

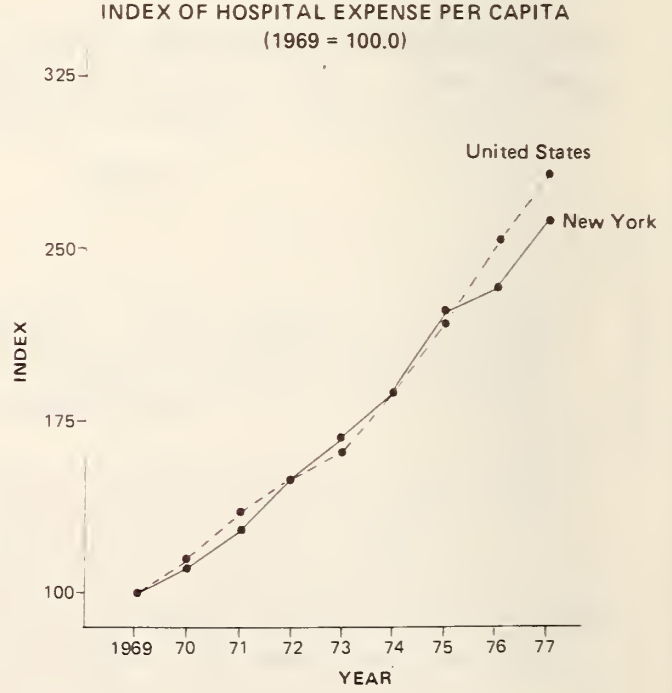
Figure 2

COMPARISON OF HOSPITAL INDICATORS:
Expense, Total Revenue and Assets
for Community Hospitals, 1969-1977
NEW YORK vs. U.S.









*Per adjusted patient day.

Sources: U.S. Bureau of the Census
American Hospital Association, *Hospital Statistics*

graphs should not be attributed necessarily to the PR system, since other effects have not been controlled for.

ADOPTION

Pressures Leading to Adoption

Prospective reimbursement is by no means a recent phenomenon in the state of New York. Prior to 1966, under the state's welfare program, hospitals were reimbursed prospectively by the Department of Social Services for welfare patients, based on mandated maximum permissible rates. Nursing home reimbursement rates were negotiated between the local commissioners and the providers. Blue Cross reimbursement formulas and rates were approved by the Commissioner of Social Services and by the Superintendent of Insurance. However, there was no state requirement for cost-based rates;[1] and, in many instances, it is likely that hospitals were underpaid for public assistance cases. Such underpayments probably were the most effective cost-limiting factors in existence at that time.[2]

Under New York's public assistance program in the early 1960s, local counties (whose financial responsibility was heavy under the federal-state-local cost share formula for hospital care reimbursement) and Blue Cross subscribers were experiencing considerable financial stress as the expenditures for hospital care increased. The state government responded in 1964 with two actions:

- The legislature passed the Metcalf-McCloskey Act, which required prior approval by the Department of Social Services of any hospital construction or renovation; and

- Governor Rockefeller appointed a committee of citizens to study hospital costs, chaired by Marion B. Folsom.

By 1965, the Folsom Committee had made several recommendations to the state legislature, which became law that same year in the form of Article 28 of the New York Public Health Law. Under this law, the state Department of Health received overall regulatory responsibility for hospitals, including Certificate of Need, construction and architectural inspection, operating certification, and rate setting. In accordance with this

---

[1]Blue Cross, however, has been cost based since 1960, and in fact, was prospective from 1948 to 1959.

[2]Ingram, Hollis, S., M.D., Regulating Costs New York Style, the Cost-Ceiling-Prospective Rate Approach, Albany, NY: New York State Department of Health, 1972.

law, the Commissioner of Health was empowered to certify rates and schedules for hospital payment for both public programs and Blue Cross plans, subject to the approval of the state Budget Director and the Superintendent of Insurance. For the first time, rate schedules for payment by public agencies were to be based on costs of producing the services. In addition, the Commissioner was given broad rule-making authority in the areas of financial reporting and record keeping.

In 1966, the state Department of Health established a prospective reimbursement cost-based formula for welfare recipients. The formula, simply stated, applied a projection factor to historical costs reported by the hospital. The projection factor was based on a three-year moving average of the cost experience in the individual hospital, and group ceilings were established to limit reimbursement to those facilities that had reported costs in excess of a peer-group maximum. In the same year, the state passed the necessary legislation to implement the Medicaid Program under Title XIX. But 1967 federal regulation required that Medicaid payments for inpatient services be computed according to the Medicare program's "reasonable cost" retrospective principles, so the state of New York, only one year after establishing a prospective formula, adopted retrospectivity.

The hospital sector, virtually assured full reimbursement for costs incurred by approximately 82 percent of the inpatient population, broadened the scope of services and added facilities, which caused costs to spiral. At the same time, New York hospitals lost their exempt status in collective bargaining, the state minimum wage was raised several times, and the federal Fair Labor Standards Law was extended to hospitals, which increased minimum salaries for hospital employees from $88.00 per week in 1968 to $130.00 per week by 1971.

The cost of the state's portion of the Medicaid program became extremely high as the counties struggled to obtain additional appropriations for their own strained budgets and were forced to prepare even larger budgets for the following year. This situation exacerbated the imminent fiscal crisis in the state. The first reaction to these fiscal pressures took place in 1968, when the state reduced Medicaid eligibility levels. Also in 1968, the state adopted a uniform financial reporting system (applicable to 1967) to collect the basic data for determining payments under Medicare, Medicaid and Blue Cross. By 1969, when neither the state's Medicaid nor general fiscal problems had been alleviated, a number of drastic measures were taken by the state legislature in a fierce attempt to control costs. Once more, Medicaid eligibility was cut back severely; an amendment was enacted that would freeze hospital rates for Medicaid payment from March of 1969 until December 31, 1971. Predictably, displeasure was voiced loudly by the hospital sector, and two weeks later the remainder of the two-year freeze was eliminated by the legislation and replaced by broad financial controls in the form of the Hospital Cost Control Act, Chapter

957 of the Laws of 1969. (The remaining nine-month freeze was eventually overturned by court action on the grounds of nonconformity with federal regulations, and costs were reimbursed to the hospitals for this period.)

The Hospital Cost Control Act of 1969, which became the state's major vehicle for containing costs in the hospital sector, was implemented January 1, 1970. The amendment to Article 28 again called for prospective rate setting, to be certified by the Commissioner of Health. However, while Article 28 originally required that certified rates be reasonably related to cost of providing service, the revision required that rates be related to the efficient production of services. In addition, under the new law, Article 9C corporation (Blue Cross) plans were also to establish prospective rates, which meant that approximately fifty-five percent of the hospitals' income statewide would be determined prospectively. Blue Cross, particularly in upstate New York, and the state's hospitals were completely unprepared for such revision. Although strict guidelines for developing a formula were specified in Part 86 of the state health department's rules, Part 86 allowed the Blue Cross plans to develop their own formula "not inconsistent" with the legislation and the principles of reimbursement as promulgated by the Commissioner in implementing the law. The state did not mandate the actual formula to Blue Cross, partly because it was felt to be politically unwise to do so, and partly because Blue Cross in New York City was already developing a more sophisticated prospective reimbursement formula.

With little time to prepare, the Department of Health and Blue Cross set out to develop their formulas. The seven Blue Cross plans in upstate New York, unprepared for such a monumental task, pooled their efforts for the first time in their history to establish one formula for setting rates across all the regions. Interim formulas were quickly developed with consultation from the hospital sector in strict compliance with the law. The hospitals, again dismayed, brought heavy complaints to the Blue Cross plans, who, after questioning the Department of Health about restrictions, negotiated a new formula with the Hospital Association of New York State (HANYS), which was instituted in the second half of 1970. The precedent for negotiation between the hospitals and Upstate Blue Cross was thus set for several years. The state also revised its formula for the second half of 1970 from a projection based on a three-year averaging technique to one based on only the previous year's average.

During the first three years of operation, the reimbursement periods were changed from calendar year to fiscal year, and once again returned to a calendar-year basis. A lag developed because of the amount of time it took to establish the rates. In 1973, prospective reimbursement in New York State was formally approved, retroactive to January 1970, under federal law PL 92-603. In 1974, two bills were passed by the legislature, one that required at least sixty days' notification of the following year's rates, and another that required outpatient deficits to be included in Blue Cross inpatient per diem rates. However, due to continual delays in rate

setting, prospective rates were not determined before January 1 of a given rate year until the rate year of 1977.

Subsequent Fiscal Pressures and New Legislation

While the Hospital Cost Control Act and Part 86 rules and regulations have been modified almost every year since their inception, the changes were minor until the fiscal problems of New York City and the state reached serious proportions in 1975. Accordingly, six major changes were incorporated into Chapter 76 of the Laws of 1976. First, outpatient and emergency service rates for Medicaid were frozen at the 1975 levels. Second, the ceiling disallowance on routine costs was dropped from 110 percent to 100 percent of the group average. Third, a ceiling penalty on ancillary costs was instituted at 100 percent of the group average. Fourth, because an Institute of Medicine study had indicated that approximately ten percent of intern and resident salaries was spent on education, and because Medicaid paid only for direct inpatient care, ten percent of intern and resident salary expense was disallowed in the rates. Fifth, Medicaid eligibility levels were cut back in several areas, and Medicaid payment for certain types of surgery was modified, based on determinations such as medical necessity, preoperative stay, and second opinion.[1] Finally, increases in Medicaid rates were to be correlated with the ability of the state to pay. Therefore, the state Director of the Budget would "take into consideration economic conditions within the state which affect the economic resources available to meet the cost of government-funded medical services."[2] If resources were unavailable to fund services at the proposed new rates, the rates would be returned to the Commissioner of Health for reconsideration. The Commissioner would then be directed to revise the rates so that the state could afford the total Medicaid bill.

These changes were further supplemented in 1977 with a length of stay penalty. The state Department of Health recognized that the imposition of occupancy penalties provided an incentive to hospitals to increase length of stay. (In fact, length of stay in New York State had remained constant at a time when it was decreasing nationally.) Therefore, in 1977, hospitals were grouped and routine costs of excess days over an average length of stay were not paid. Hospitals reacted to these additional constraints by bringing several court suits against the state Department of Health.[3] In addition, one hospital cancelled its Blue Cross contract and several others threatened to do the same. Since these hospitals were located in areas where access to care might have been seriously jeopardized, the state responded in 1978 with a charge control bill, which froze charges as of May 1, 1978. Also, any hospital which had terminated its Blue Cross contract

[1]These allowable service definitions and subsequent changes are discussed in more detail in the section on interactions.

[2]Laws of New York, 1976, Chapter 76, p. 6.

[3]These suits will be discussed at length in the appeals and litigation section.

could not charge more than the prospectively set per diem rate for a given patient. Moreover, charges for 1979 and succeeding years could only increase by an amount equal to the calculated trend factor.

Besides these constraining changes there were several additions that were favorable to the industry. First, a council of four independent health economists was appointed by the governor to determine a methodology for calculating the trend factor, thus transferring this responsibility from the state Department of Health to an independent body, which presumably would be more objective in evaluating likely inflationary trends in input prices. Second, the Commissioner of Health was directed to include in the trend factor calculation such items as appropriate external price indicators and data from major Department of Labor collective bargaining agreements of nonsupervisory employees. Third, the appeals process was clearly identified in the legislation and included as appealable items significant increases in costs due to labor settlements, new services, or increases in bad debts. Finally, because of the many changes in reimbursement methodology in the state, and because the overall hospital financing structure of the state had not been comprehensively evaluated since the 1965 Folsom Committee study, a Council on Health Care Financing was created to examine, study in depth, and develop a new system of financing general hospitals in the state. The Council was directed to review with particular care the impact of recent legislation, departmental rules and regulations, and court decisions on the health care reimbursement system in the state. The Council was further directed to submit recommendations to the governor and the legislature for the establishment of a uniform mechanism for financing general hospital inpatient care, including methods of establishing equitable payment from all sources.

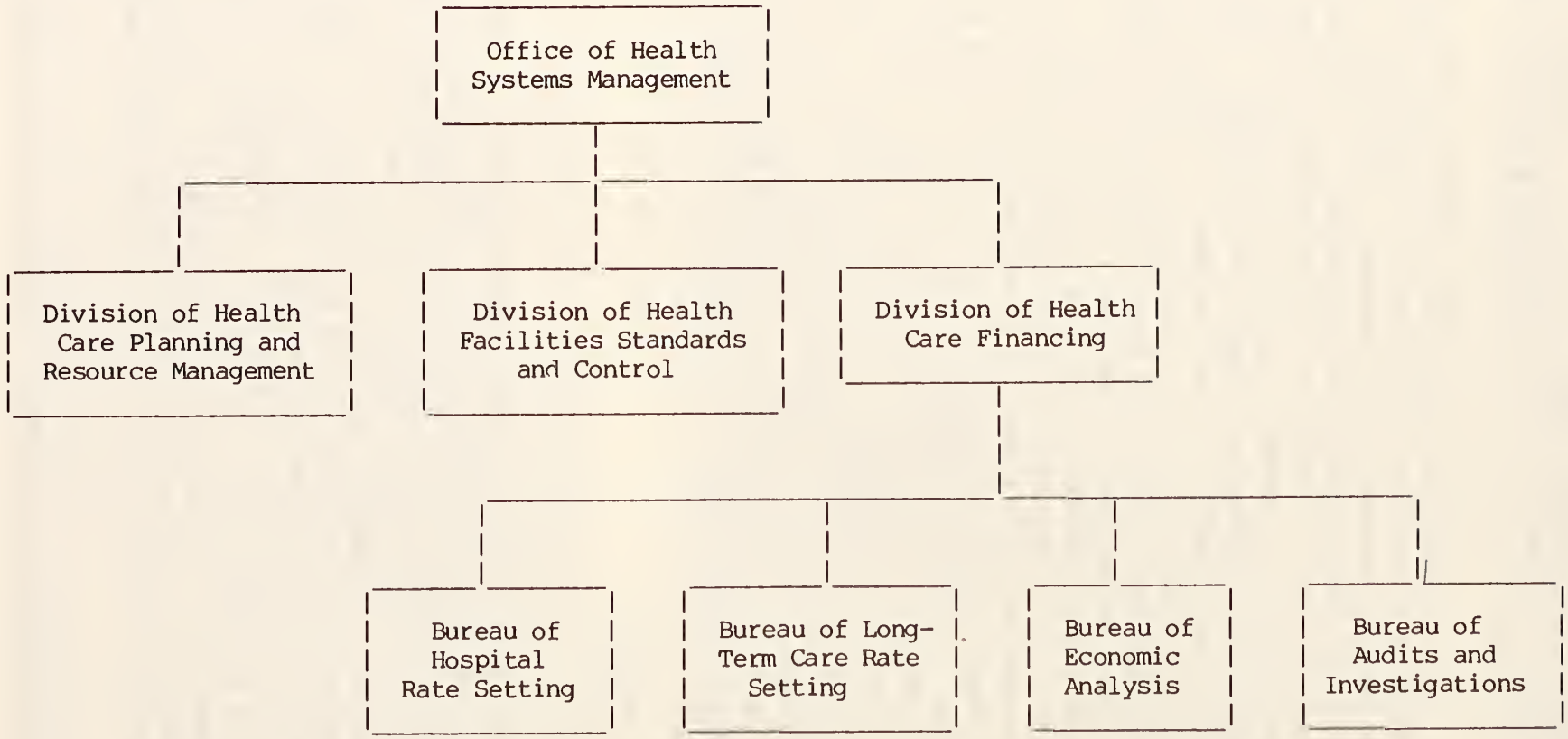
CONTENT AND PROCESS

Organization

The body responsible for setting prospective rates in New York State is located within the Division of Health Care Financing of the Office of Health Systems Management in the New York State Department of Health. There are several bureaus within the Division of Health Care Financing, each with separate rate-setting functions (see Figure 3). The Bureaus of Hospital Rate Setting and Long-Term Care Rate Setting are responsible for actually setting Medicaid rates and deciding appeals, with input from the other bureaus.[1] The Bureau of Economic Analysis is responsible for the calculation of the trend factor, utilizing the methodology established by the four-member panel of independent health economists. Finally, the Bureau of Audits and Investigations is responsible for providing accurate cost data to the rate-setting bureaus for rate calculation and settlement of appeals.

[1]The Blue Cross plans are responsible for calculating Blue Cross rates.

FIGURE 3: Location of Rate-Setting Body within State Department of Health


Office of Health Systems Management
Division of Health Care Planning and Resource Management
Division of Health Facilities Standards and Control
Division of Health Care Financing
Bureau of Hospital Rate Setting
Bureau of Long-Term Care Rate Setting
Bureau of Economic Analysis
Bureau of Audits and Investigations

In addition to these bureaus are three external groups, which provide input to the rate-setting process. As mentioned earlier, there is a four-member panel of independent economists (established by the 1978 legislation), who are charged with developing the methodology for calculating the trend factor. Also as discussed earlier, the Health Care Financing Council (established by the same 1978 legislation) is charged with developing a more efficient and equitable reimbursement system. This bipartisan Council is a joint executive-legislative council, with nine members who are appointed by the Governor and both parties of the legislature. Both labor and industry are represented on the Council, which has the following six subgroups:

- Reimbursement Methodology, to review the methodology for rate calculation and determination of the payment unit;
- Cost Criteria, to determine allowable costs, limits to be set, appropriate peer groupings, appropriate types of year-to-year comparisons, and policies for the payment of bad debts and intern and resident salaries;
- Insurance, to determine the relationship between Blue Cross and other commercial insurors (i.e., should Blue Cross have an advantage or should there be more competition?);
- Health Maintenance Organizations, to consider obstacles to general hospitals in setting up HMOs;
- State Mandates, to consider the cost of regulation and regulatory duplication; and
- Legal Considerations, to determine whether proposals are legal and how they can be implemented (e.g., will federal waivers be needed or will Part 86 need to be changed?).

The Council's first meeting was held in October 1978; it is just gaining momentum as a viable group. Most of its activity has been concentrated in working meetings among the various subgroups.

Finally, the Hospital Review and Planning Council, established originally in Article 28 and whose members are appointed by the Governor, reviews and approves all proposed changes in Part 86 rules and regulations. The Council may receive monthly proposed changes in the rules. The Committee on Fiscal Policy (a subcommittee of the Council) then holds an open hearing with industry representatives, the Rate-Setting Bureau, and legal counsel to

discuss the proposed changes. The Committee then holds a second meeting with the Deputy Commissioner, his assistant, and one industry representative. At this time, a final recommendation is developed and presented to the full Council for approval.

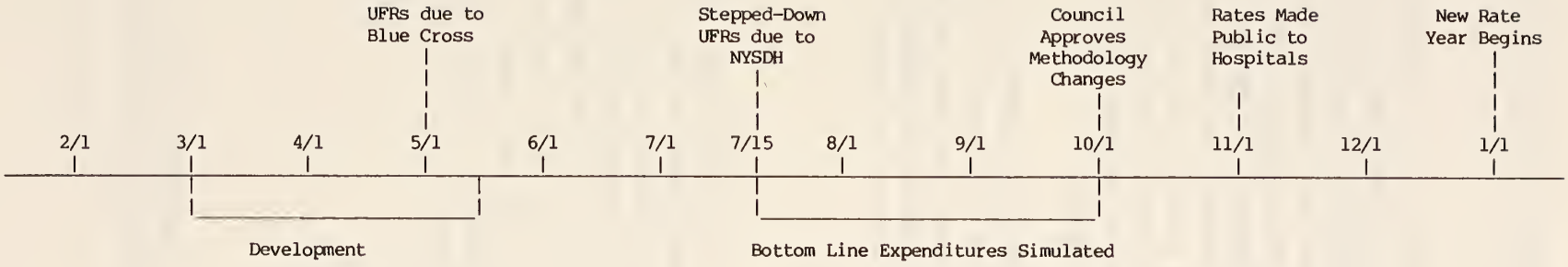
In order to understand the workings of the Council more clearly, a discussion of several of the more controversial proposals put forth to the Council is warranted. In 1977, the Office of Health Systems Management (OHSM) proposed a disallowance of twenty percent of intern and resident salaries, a proposal not recommended by the Council. In 1978, OHSM proposed to build the concept of a fixed state dollar amount into the Part 86 rules and regulations. This dollar amount would then be allocated on a regional basis to the Health Systems Agencies (HSAs), and new programs would be reviewed as a group. This concept was proposed as a legislative change; however, the industry actively opposed it, and the change ultimately was rejected by the Council and the legislature. One unofficial reason given was that the dollar amount set for the state by OHSM was below the dollar amount needed for New York City alone.

Timing

As mentioned previously, since January 1970, there have been many changes in the rate year period, as well as delays in setting prospective rates. However, there is an ideal timing process in the setting of the rates, which, if strictly followed, would produce prospective rates sixty days prior to the beginning of the rate year. The time-line for this process is illustrated in Figure 4.

Generally, March through May represents a developmental period for the New York State Department of Health (NYSDH). Rudimentary analysis of historical data is done for such items as cluster analysis, wage-geographic differentials, and minimum wages. The Uniform Financial Reports (UFRs) are sent to Blue Cross at the end of April. Each Blue Cross plan then audits the UFRs and forwards them to the Downstate Blue Cross plan for computerization and step down. These step downs are due at the NYSDH by July 15. From July 15 through October 1, when final rate methodology is approved by the state Hospital Review and Planning Council, the NYSDH considers alternative rate methodologies, simulates the dollar impact of each on expenditures, and negotiates a methodology with the Budget Office for presentation to the Council. Once the rate methodology is approved, the rates are submitted to the Commissioner of Health, who certifies them and then submits them (Blue Cross only) for approval to the Superintendent of Insurance. As mentioned earlier, both delays in setting Medicaid rates (until 1977) and differences in the rate-year period have been characteristic of the prospective reimbursement system in New York State.

FIGURE 4: Ideal Time-Line for Rate-Setting Process



Process

Allowable Costs

For both Medicaid and Blue Cross, allowable costs generally are determined by the application of Medicare principles of reimbursement to costs that are properly chargeable to necessary patient care. Historical cost depreciation is reimbursed on a straight-line method for plant and nonmovable equipment, and a straight-line (Upstate Blue Cross) or accelerated method[1] for movable equipment. Interest on current and capital indebtedness (less interest income), as well as educational activities (less tuition and supporting grants), are considered allowable; however, as mentioned earlier, ten percent of intern and resident costs are disallowed. A return on equity is allowed for proprietary hospitals. Finally, research costs are not considered allowable.

One major difference between the Medicaid and Blue Cross definitions of allowable costs involves the treatment of outpatient deficits. Blue Cross, in its voluntary inpatient per diem rates, must include their portion[2] of any net loss in nonreferred ambulatory and emergency services, adjusted by any excess revenues over expenses from all other hospital services.

Grouping Mechanisms

Until 1977, the Medicaid and Blue Cross peer groupings used to calculate ceilings and disallowances were based on several general characteristics of hospitals: facility type, geographic area, bed size, and sponsorship (Medicaid only). Table 1 shows differences in the characteristic definitions used by Medicaid and Blue Cross for type of facility, geographic area, size of facility, and sponsorship. In 1977, the state changed the grouping system for calculation of the Medicaid rates in favor of cluster analysis. Hospitals were then grouped using a statistical clustering technique and the variables indicated in Table 2.

---

[1]Double declining balance or sum-of-the-years digits method.

[2]"Their portion" means Blue Cross inpatient days as a percentage of total inpatient days.

TABLE 1: Differences in Medicaid and Blue Cross Groupings

Blue Cross	Medicaid
a. Type of Facility	a. Type of Facility
teaching	teaching
general	general
special	special
	nursing homes
	health-related facility
	out-of-hospital health facility
b. Geographic Area	b. Geographic Area
service areas of the seven Upstate Blue Cross plans	N.Y. metropolitan SMSA[1]
	upstate SMSA
N.Y. City and counties in downstate area	upstate non-SMSA
c. Size	c. Size
bed size (upstate)	volume of patient days
patient days (downstate)	
d. Sponsorship	d. Sponsorship
not included (upstate)	voluntary hospitals
voluntary (downstate)	public hospitals
proprietary (downstate)	proprietary hospitals
	voluntary nursing homes
	public nursing homes
	proprietary nursing homes

[1]Standard Metropolitan Statistical Area.

TABLE 2: Variables Used in Cluster Analysis

Teaching Hospitals
number of teaching programs
number of residents receiving training
size of facility
patient mix of facility (percentage Medicare and Medicaid)
service mix
Nonteaching Hospitals
size of facility
patient mix of facility
service mix
Specialty Hospitals
type
size of facility
patient mix of facility
service mix

The clustering technique using these variables resulted in thirty-four groups, which are thought to represent a more meaningful grouping structure in terms of hospital homogeneity.

The Trend Factor

Because per diem rates for any rate year (t) use data from the base year (t-2), an upward inflationary adjustment for two periods is necessary. The calculation of the first period's rate of inflation is a weighted average of rates of inflation for hospital wages and other costs. In estimating increases, hospitals are generally grouped by location, type, and size and receive a specific wage inflation rate in each group. The inflation rate is then weighted by the percentage of expenses on salaries.[1] Nonlabor inflation rates are calculated in a similar way, generally using external inflation indices from the CPI or WPI. These inflation indices are then weighted by the percentage of total expenditures for each nonlabor input. The level of detail sought by the NYSDH in calculating inflation in nonlabor costs through the years is quite notable. For example, indicators

[1]Sources for the wage inflation rates have varied over time and by type of hospital and will be discussed below.

are gathered for such detailed categories as malpractice insurance, soap and detergent, and No. 2 fuel oil.

As discussed earlier, there have been differences both over time and among types of hospitals in the calculation of the wage inflation rate. These changes and differences are quite detailed and complex. For evaluation purposes, however, it is sufficient to make particular note of two important differences or changes: the use of external or internal (to the hospital industry) data to calculate wage movements, and differences in allowable wage increases due to unionization. These factors are discussed below as they developed chronologically.

In general, Medicaid wage inflation indices used before the Economic Stabilization Program (ESP) were internal to the industry for two reasons. First, it was felt that wages in the industry were lower than in comparable occupations in other industries and would, therefore, increase at an accelerated rate annually. Second, the formation of unions and the process of collective bargaining, given the generally lower base of hospital wages, was felt to be, for the most part, beyond the control of hospital administrators. Therefore, for the first rate period, wage inflation rates were calculated from a salary survey of selected hospital titles of the New York State Department of Civil Service. For the second rate period, the wage inflation rate calculation was more complex and differed for New York City and upstate hospitals. The rate allowed was the lower of: 10.5 percent for upstate hospitals and 12.5 percent for New York City hospitals, or a trend factor calculated from first quarter data of the IRS Report no. 941.[1]

For the rate periods of 1973 and 1974, hospitals were generally held to at least the external guidelines under ESP. In 1973, all hospitals were given an allowable 5.5 percent increase in wages. In 1974, all upstate and some New York City hospitals were given the lower of either 5.5 precent or an inflation rate calculated from the New York Civil Service Survey. However, in terms of allowable wage inflation rates, 1974 was a departure year for member hospitals of the League of Voluntary Hospitals (heavily unionized by District 1199), "tandem"[2] hospitals in New York City and member hospitals of the Association of Private Hospitals.[3] For these hospitals, collective bargaining agreements were taken into account in setting the wage inflation rates.

---

[1]Internal hospital report.

[2]"Tandem" hospitals are those hospitals whose wages generally move in tandem with those of hospitals in the League of Voluntary Hospitals.

[3]The type and extent of unionization in these New York City hospitals are discussed more fully in the section on interactions.

While this approach continued in the 1975 rate year for these New York City hospitals, the NYSDH continued to use external data for the upstate inflation rates. In this year, the general rate of wage inflation was set at six percent and was calculated from a survey of collective bargaining agreements for selected occupations excluding hospitals across the state.[1]

In the 1976 rate year, the policy of using external indicators for upstate hospitals continued; however, for the League of Voluntary Hospitals (LVH), tandem hospitals and the Association of Private Hospitals (APH), the lower of their internal indicators or the external indicators determined the allowable inflation rate, a policy that continued through the rate period of 1977. Also, as of 1977, the trend factors developed by the NYSDH were mandated for inclusion in the Blue Cross formulas.

In 1978, the charge control legislation stated that, in setting a wage inflation rate for the trend factor, the NYSDH should take into account collective bargaining agreements with hospitals. In addition, the state implemented the Supplemental Hospital Index Factor (SHIF), which allowed for an additional percentage increase in the wage inflation rate if the hospital qualified under certain financial stress conditions and had entered into a multi-year collective bargaining agreement or a written commitment to increase wages. This situation generally covered LVH and tandem hospitals in New York City. The agreement was to continue through mid-1980, so New York City hospitals were essentially guaranteed a wage pass-through. Non-SHIF hospitals, whose wage inflation rates had been calculated from New York State collective bargaining agreements excluding hospitals, continued to receive the same external indicators.

For the 1979 rate year, the SHIF policy continued for LVH and tandem hospitals. For non-SHIF hospitals, however, the trend factor panel of health economists, with urging from the American Federation of State, County, and Municipal Employees (AFSCME), who felt that the national increases were higher than increases in the State of New York, recommended the use of national collective bargaining data for determining the wage inflation rate.

Table 3 below summarizes these Medicaid changes in abbreviated form for each of the rate periods. Of particular importance is whether price movements for wages have been external or internal to the hospital industry. For Upstate Blue Cross, internal wage increases were used in their inflation rates until 1974; in 1975, Upstate Blue Cross changed to external indices. Downstate Blue Cross has used external indices in all years.

---

[1]In 1974 and 1975, some hospitals were allowed their internal rates if they were approved by the Cost of Living Council.

TABLE 3: Sources of Wage Price Movements in New York State Trend Factor

Rate Period	Internal/External	Source of Wage Price Movement
July 1970 to June 1971	Internal for all hospitals	Salary survey of selected hospital titles of New York State Department of Civil Service
July 1971 to December 1972	Internal for all hospitals	Lower of (1) 10.5 percent for upstate hospitals 12.5 percent for New York City hospitals or (2) trend factor calculated from first quarter IRS Report #941
January 1973 to December 1973	External for all hospitals	5.5 percent ESP guidelines
January 1974 to December 1974	• Internal for League of Voluntary Hospitals, tandem and Association of Private Hospitals • External for all other hospitals	Data from collective bargaining agreements Lower of (1) 5.5 percent ESP guidelines or (2) Salary survey of selected hospital titles of New York State Department of Civil Service
January 1975 to December 1975	• Internal for LVH, tandem and APH hospitals • External for all other hospitals	Same as above Six percent - calculated from survey of collective bargaining agreements for selected occupations excluding hospitals across state
January 1976 to March 1977	• Lower of internal or external for LVH, tandem and APH hospitals • External for all other hospitals	External sources included Public Employment Relations Board, Department of Civil Service, average weekly earnings for selected manufacturing and non-manufacturing industries, and contract settlements reported by New York City Office of Collective Bargaining and New York State Department of Labor
April 1977 to December 1977	Same as above	Same as above
January 1978 to December 1978	• Internal for LVH and tandem hospitals (SHIF) • External for all other hospitals	Collective bargaining agreement with hospitals (commitment with SHIF is through 1980) Same as above
January 1979 to December 1979	Same as above	Sources for external movements include Employment Cost Index (ECI) Series U.S. Bureau of Labor Statistics and average wage increases covered under major collective bargaining agreements as reported in Current Wage Developments, U.S. Bureau of Labor Statistics

Formula and Disallowances

A review of the general formula for calculating rates is necessary for understanding various differences between the Medicaid and Blue Cross systems, as well as changes in these systems over time. The following discussion concentrates on the current Medicaid formula, which has been briefly described in the Introduction.

The Medicaid Formula. In calculating the Medicaid formula, routine allowable expenses are adjusted first by a wage geographic differential, which places the wage and salary component of a hospital's costs on a base comparable to that of New York City. Next, routine costs per patient day for the hospital are compared to those of its group, and anything over 100 percent of the mean is disallowed. Then ancillary costs per discharge for the hospital are compared to those of its group, and anything over 100 percent of the mean is disallowed. The average length of stay for the hospital is then compared to the group's average length of stay plus one-half day. Any excess days over this are multiplied by the hospital's total discharges to compute total disallowed patient days. This figure is then multiplied by the lower of the group's routine per diem ceiling or the hospital's routine per diem, to give a total dollar disallowance from allowable operating expense.[1] Next, 10 percent of intern and resident costs are disallowed.

To obtain the numerator of the formula, allowable routine, ancillary and education costs are added together and trended for inflation to the rate year, and capital costs are added to this figure. In algebraic form,

$$INP = [(ROUT + ANC + ED) \times t] + CC,$$

where

INP = allowable inpatient costs,

ROUT = allowable routine costs,

ANC = allowable ancillary costs,

ED = allowable education costs,

t = two-year trend factor, and

CC = allowable capital costs.

---

[1](Excess days) x (Total Discharges) x (Lower of group's routine per diem ceiling or hospital's per diem) = Total Dollar Disallowance.

The denominator is calculated by adding any imputed patient days to the hospital's actual inpatient days. The hospital will have imputed days if it fails the occupancy criteria, as detailed below:

Medical/Surgical: 80% if hospital is located in an area with fewer than 100 persons per square mile. [1]

85% if hospital is located in an area with more than 100 persons per square mile.

Pediatric: 70% if hospital is located in an area with fewer than 100 persons per square mile.

75% if hospital is located in an area with more than 100 persons per square mile.

Maternity: 60%

If the hospital's occupancy rates fall below these criteria, enough patient days are added to the denominator of the formula to reflect these occupancy levels. The formula for calculating the per diem rate can be represented as follows:

$$\text{Rate} = \frac{[(\text{ROUT} + \text{ANC} + \text{ED}) \times t] + \text{CC}}{\text{PD} + \text{IPD}} = \frac{\text{INP}}{\text{PD} + \text{IPD}}$$

where

PD = hospital's patient days and

IPD = imputed patient days due to any of the above occupancy penalties.

The Medicaid formula as it currently exists is the result of many changes that have been made since its inception in 1970, when Medicaid formula penalties were less constraining. Until 1976, only routine costs were penalized, and these costs were disallowed only if they were in excess of 110 percent of the peer group average. This figure changed to 100 percent in 1976 and has remained at that level since. Also, beginning in 1970 and until 1977, the occupancy minimums remained at eighty, seventy and sixty percent respectively for Medical/Surgical, Pediatric, and Maternity patient days. In 1977, the Medical/Surgical occupancy penalty was changed to eighty-five percent and the Maternity penalty was also changed; if a hospital was located in an area with more than 100 persons per square mile,

[1]The density distinction is made so as not to stringently penalize rural hospitals.

the rate for maternity days would be determined as the highest figure computed from one of the following three formulas:

- that amount equal to seventy-five percent occupancy, or
- if the hospital had fewer than 1500 live births, the difference between 1500 and the actual number of live births, times the average length of stay for a maternity patient, plus their actual maternity days, or
- if the hospital had more than 1500 live births, the number of actual maternity days.

However, if the hospital was located in an area with fewer than 100 persons per square mile, the number of maternity days would be obtained by the highest figure computed by:

- that amount equal to sixty percent occupancy, or
- if the hospital had fewer than 500 live births, the difference between 500 and the actual number of live births, times the average length of stay of a maternity patient, plus their actual maternity days, or
- if the hospital had more than 500 live births, the number of actual maternity days.

Additional ceiling penalties were added in 1976. Ancillary costs were disallowed if in excess of 100 percent of the peer group average ancillary cost per discharge. In addition, beginning in 1976, ten percent of intern and resident costs were disallowed. The penalties were changed further in 1977. An average length of stay penalty was added in which excess days over the peer group average plus one-half day were disallowed. Also, the occupancy penalties were changed to conform to the criteria discussed earlier in the description of the current Medicaid system. Finally, due to the tremendous number of appeals that had to be settled, the Medicaid rates for 1979 were calculated by simply trending the 1978 rates, effective only for 1979.

The Upstate Blue Cross Formula. The Upstate Blue Cross formula differs from Medicaid and has also changed over time. Beginning in 1970, there were four distinct differences in the two formulas. First, the Upstate Blue Cross trend factor included a "technology" factor (dropped in 1975) to reimburse hospitals for at least part of the increase in the intensity of services per patient day. The component was calculated as the percentage change in nonlabor costs in ancillary departments, minus the percentage change in the price index of nonsalary costs. Hospitals were grouped into two categories, SMSA and non-SMSA, within each Upstate Blue

Cross plan, with each hospital in a group receiving the group average up to a maximum of 1.7 percent. Second, as discussed in the section on allowable costs, the formula included a portion of bad debts and charitable allowances called a "Community Service Factor." This Community Service Factor was superseded through a legislative amendment to Part 86 in 1975 by a broader methodology to compensate for the loss in outpatient services. Third, there were no utilization penalties in the Upstate Blue Cross formula until 1973. In that year, a sixty percent occupancy limit was incorporated into the formula, and in 1974, Blue Cross adopted Medicaid's eighty, seventy and sixty percent occupancy limits for Medical/Surgical, Pediatric, and Maternity patient days.

In 1976, the Blue Cross formula began to conform much more to the Medicaid formula. The 100 percent disallowances on routine and ancillary services and the ten percent disallowance on intern and resident salaries were incorporated into the formula. In 1977, a length of stay penalty (although slightly different from Medicaid's) was added, and Upstate Blue Cross adopted the Medicaid trend factor. Finally, in 1978, Upstate Blue Cross combined the routine, ancillary, and length of stay penalties into one penalty, using the following procedure. An average length of stay was calculated for each group, and an extra day was then added. The ratio of total patient days for the group to this figure yields imputed discharges. Total routine and ancillary costs for the group were then divided by the group's imputed discharges to yield the group average cost per discharge ceiling.

The Downstate Blue Cross System. While the Downstate Blue Cross formula generally follows the principles of the Medicaid and Upstate Blue Cross formulas, it differs from them in some ways, as well as over time. First, until 1976, the ceiling penalties for Downstate Blue Cross differed from both Medicaid and Upstate Blue Cross formulas. Hospitals were first grouped, and an initial group average (routine and ancillary) operating per diem was calculated. At that point, all hospitals whose costs were either under 85 percent or above 115 percent of the initial average were equalized to 85 percent under or 115 percent over the average, respectively, and a final peer group average was calculated. Any actual hospital costs higher than 115 percent of this new group average were considered excessive. Thus, while the percentage amount disallowed for Downstate Blue Cross was higher (115 versus 110 percent) than the Medicaid and Upstate Blue Cross disallowances, both routine and ancillary costs were penalized and group averages were calculated on data with a smaller range.

Second, until 1977, the Downstate Blue Cross method of trending base-year rates to obtain allowable rate-year costs was different from the trending used by Medicaid and Upstate Blue Cross. Rather than applying an inflation factor to allowable base-year costs for the intermediate year, Blue Cross used the actual experience of the hospital. The hospitals were grouped, and an average percentage increase in per diem operating costs from

the base to intermediate year was calculated. This percentage increase then became the allowable percentage increase for all hospitals in the group. The new intermediate year amount was then trended for expected inflation in the rate year to arrive at rate-year operating expense.

In 1971, the trending from base to intermediate year was changed. Hospitals were allowed their actual percentage increase, provided it was not less than 80 percent and no more than 120 percent of the peer group average increase. This corridor changed again in 1972, when it was set equal to 90 percent below and 110 percent above, and again in 1975, when it reverted back to the 80 and 120 percent corridor. It remained at these levels until 1977, when Downstate Blue Cross adopted the Medicaid method of trending from base to rate year, as well as the same trend factor allowance.

Third, until 1975, the amount allowed as return on equity to proprietary hospitals differed for Medicaid and Blue Cross. The Medicaid system allowed a percentage reasonably related to the money market; Blue Cross allowed a percentage equal to the average prime rate plus two percent of the hospital's average equity in tangible assets. In addition, the Blue Cross rate of return was applied to assets, which included net working capital. This item was not included in Medicaid's definition of assets. In 1976, Blue Cross changed its policy on return on equity and adopted the Medicaid definition.

Fourth, unlike Medicaid, Downstate Blue Cross allowable nonoperating expenses included the Upstate Blue Cross Community Service Factor for bad debts and charitable allowances.

Fifth, while the Downstate Blue Cross reimbursement methodology included dialogue relating to underused services, occupancy ceilings were applied only at the discretion of the plan until 1974, when the Medicaid eighty, seventy and sixty percent occupancy ceilings were incorporated across the board.

Sixth, the Downstate Blue Cross definition of inpatient days differs from that of Medicaid. An adjustment is made in the calculation of patient days to reflect private room days.[1] This is done by calculating an average private and semi-private room charge, and weighting the charges of different rooms by the percentage of beds of each room type. The average charge for semi-private rooms is then subtracted from that of private rooms, giving an average private room differential. Next, this differential is divided by the allowable per diem rate, giving the percentage of per diem costs attributable to the difference in cost between a private and semi-private room. This percentage plus one is then used to weight private

[1]Since hospitals may charge their Blue Cross subscribers for the private room differential, these costs must be subtracted from the Blue Cross rate.

room patient days, which, when added to the sum of nonprivate room days, gives the total weighted patient days.

Seventh, for several years the Downstate Blue Cross method incorporated productivity incentive payments in its rates. From 1970 through 1973, a hospital would be allowed to retain some portion of any labor cost savings generated, if it could show that labor productivity had increased as a result of acquiring new capital assets. These savings would be incorporated into the rates for the following five years at the rate of 100, 80, 60, 40 and 20 percent, respectively. In no case, however, would the productivity incentive payment exceed three percent of allowable operating costs for the period under review. This incentive was dropped altogether from the 1974 system and reintroduced in the 1975 system, but with a different methodology. In 1975, a percentage increase was added to the trend factor to cover costs resulting from expansion and improvement of services, technical developments and improvements, and costs resulting from changes in the use of services by the community. The percentage increase varied from 0.5 to two percent, depending on the hospital's group. This was changed again in 1976, which was the last year it was incorporated in the methodology. In that year, hospitals were entitled to a productivity incentive payment if they could demonstrate a two-percent increase in employee productivity in the rate year as compared with the intermediate year. If so, the hospital would receive one-third of the percentage increase times the per diem of the productivity year.

In 1976, the Downstate Blue Cross formula began to conform more closely to the Medicaid formula and changed its routine and ancillary ceiling penalties to reflect the Medicaid penalties. Again, as with Upstate Blue Cross, the routine, ancillary, and length of stay penalties were combined into one major penalty in 1978.

Finally, in 1979, the peer group disallowance corridor changed from 100 percent to 102 percent. Table 4 details the different formula components for Medicaid, Upstate and Downstate Blue Cross, as well as changes in these components over time by payor.

Special Programs

The Emergency Reimbursement Program. The Emergency Reimbursement Program was added as an amendment to Part 86 in August of 1978. In order to qualify for the program, an institution must show that it is in dire financial need, that it is a needed facility according to current planning standards, that it is providing an adequate level of quality care, and that it has the commitment of the board and chief financial officers toward continued viability of the hospital. If an institution qualifies, Medicaid will reimburse the institution at a current "budgeted" cost and monitor its cash flow on a weekly basis. At the end of the rate period, actual costs will be reimbursed.

TABLE 4: Formula Content and Changes Over Time for Medicaid and Upstate and Downstate Blue Cross

YEAR	MEDICAID	UPSTATE BLUE CROSS	DOWNSTATE BLUE CROSS	CHARGE PAYOR
1970	• 110% routine penalty 80, 70, 60% occupancy penalties • Compound inflation rates = trend factor	• 110% routine penalty • Compound inflation rates = trend factor • Technology factor added to trend factor • Community service factor	• 115% routine and ancillary penalty • Actual intermediate year increase plus one year inflation factor = trend factor • Community service factor • Productivity incentive	No control
1971	No change	No change	• Intermediate year actual increase limited to 80 and 120% corridor in trend factor	No change
1972	No change	No change	• Above corridor changed to 90 and 110%	No change
1973	No change	• 60% maternity occupancy penalty added	No Change	No change
1974	No change	• 80, 70, 60% occupancy penalties	• 80, 70, 60 % occupancy penalties	No change
1975	No change	• Technology factor dropped • Community service factor dropped • Ambulatory loss factor added	• Intermediate year actual increase corridor changed back to 80 and 120% • Technology and expansion factor added to trend factor • 60, 70% nursery occupancy penalties added • Community service factor dropped • Ambulatory loss factor added	No change
1976	• 100% routine penalty • 100% ancillary penalty • 10% intern and resident salaries disallowed • Rates tied to budget	• 100% routine penalty • 100% ancillary penalty • 10% intern and resident salaries disallowed	• 100% routine penalty • 100% ancillary penalty • Nursery ceiling 150% • Productivity incentive • Volume (± 5%) adjustment	No change
1977	• LOS penalty added 80, 85% on medical/surgical occupancy penalty • 70, 75% on pediatric occupancy penalty • Live birth penalty	• LOS (110%) penalty added 80, 85% on medical/surgical occupancy penalty • 70, 75% on pediatric occupancy penalty • Went to Medicaid trend factor amount • Live birth penalty	• LOS penalty added. 80, 85% on medical/surgical occupancy penalty • Dropped productivity incentive • Went to Medicaid trend factor methodology and amount	No change
1978	No change	• LOS penalty changed to group average plus one day. Also routine ancillary and LOS penalty combined	• Routine ancillary and LOS penalty combined	Charges frozen as of May 1, 1978
1979	No change	• Rate to rate trending (one year only)	• 102% routine and ancillary penalty	Charges may increase by amount of Medicaid trend factor

The program grew out of the need to provide emergency funding to certain hospitals on the verge of bankruptcy that were considered "needed" institutions. In particular, the program was motivated by a need to save three inner-city hospitals[1] serving either an essentially no-pay or Medicaid population. In the past, the institutions had been mismanaged and showed artificially low expenditures, although the quality of care provided was acceptable. Given the particularly low cost base and the no-pay problem, these hospitals were rapidly deteriorating. Since they were not incurring any penalties, the state realized it could not rescue the hospitals through the appeals process. The anticipated solution involved a restructuring of services and a possible merger; however, some sort of "bridge mechanism" was needed in order to pay current costs and keep the hospitals stable for at least eighteen months in order to complete the necessary planning. The Emergency Reimbursement Program was quickly established, since this type of effort was not covered under the Part 86 rules and regulations.

The Hospital Closure Incentive Program. This program was enacted as an amendment to Part 86 for 1978 implementation and was motivated by the problems created by union layoffs and union resistance to hospital closings. Under this program, those personnel laid off due to the closing of a hospital are hired at another hospital in the area.[2] The receiving hospital is paid an increase in its per diem to reflect the associated staffing costs, provided that within three years the facility returns to its original staffing levels through attrition. The program was designed to serve as an incentive to reduce unnecessary beds and to encourage closings and mergers.

The Hospital Conversion Incentive Program. Also enacted as an amendment to Part 86 in July of 1978, this program closely resembles the intent and process of the Closure Incentive Program. The focus of this program, however, is on the conversion of underutilized acute hospital beds to lower levels of care. Under this program, the state audits and reimburses for additional costs to convert the beds and for the outplacement of acute care personnel.

Both of the above programs are paralleled in the Blue Cross methodology.

Data Required

In general, there are three major types of data that are required to set prospective rates and settle appeals. They include cost and

---

[1]Brooklyn Jewish, Bronx-Lebanon and Arthur Logan Memorial hospitals.

[2]Formerly agreed upon by the hospitals and approved by the local Health Systems Agency.

statistical data, diagnostic data,[1] and price trend data. The first set of data, historical cost and statistical data, is provided to the state through use of the Uniform Financial Report (UFR) and the Uniform Statistical Report (USR). The forms for reporting departmental expenses, revenues, and utilization data are consistent with the Medicare Cost Report; however, the step-down allocation is done through computer programs. There is no rate calculation in the report. Submission of these data, therefore, does not currently represent a signficant burden to the hospital industry. The second group of data, discharge data, has only been collected and used for one year, 1977, although it is the state's intention to collect these data in each succeeding year. Since sufficient data systems maintained by organizations other than the individual hospitals were utilized, the acquisition of these data does not represent a significant burden to the hospital industry in general. The final group of data needed involves price movements in a substantial number of categories. These data are used to construct the trend factor and are collected solely by the rate setters.

In summary, while the data bases used in the system are extensive, they are generally readily available and do not currently represent an undue burden on the hospital industry. For 1979, however, hospitals will be required to implement the System for Hospital Uniform Reporting (SHUR) into their operations. This system, once implemented, will achieve uniformity of reporting in New York State.

Appeals and Litigation

Appeals[2]

The number of appeals filed by hospitals in New York State to the NYSDH over the years is staggering. Until recently, adequate administrative procedures for processing these complaints had not been established. The resultant delays caused many hospitals to complain bitterly about "state-imposed financial hardships," and these delays have been used as evidence in their case for reform of the system. Currently a new format is being developed by the Rate Setting Bureau to process all appeals.

---

[1] A diagnostic data system (SPARKS) is currently being developed to combine patient bills with medical record abstracts and the cost and statistical data of the hospitals.

[2] This discussion applies to Medicaid only.

Prior to 1976, the volume of appeals was low relative to the ensuing years. However, the 1976 guidelines considerably tightened hospital rates. With a drop in the ceiling for routine and ancillary inpatient costs from 110 to 100 percent of the group mean and a ten percent disallowance of interns' and residents' salaries, almost all of the state's hospitals appealed their rates. At this time, a hospital did not have the right to a hearing; all audit and rate appeals were handled administratively. If a denial was issued, the facility could ask the Rate Review Panel to reconsider its case. No formal presentations were allowed before the Review Panel. Rather, the panel members would review the facts of the case and make a decision on the hospital's rate. Any further appeals went before the courts.

Hospitals did take the rate setters to court, and the Department began losing cases on due process issues. In 1977, therefore, provisions were made for full due process hearings regarding contested audits. Also, a Rate Setting Bureau and a separate Appeals Bureau were formed within the Department's structure. During its year-long existence, the Appeals Bureau handled 159 hospital and 500 nursing home appeals, but the astronomical number of appeals that flooded the Bureau after adoption of the even stricter 1977 regulations proved to be too much for the Appeals Bureau to handle.

On January 1, 1978, a backlog of 1200 hospital and 1200 nursing home rate appeals had accumulated in the Appeals Bureau.[1] The hospital rate appeals covered a wide spectrum, including 214 case-mix appeals, waivers of utilization penalties, capital cost issues such as new construction or corrections in past capital allotments, and program changes. The 1978 regulations, among other modifications, dropped the $\pm$5 percent volume variance allowance. All hospitals appealed. These appeals, combined with the staggering backlog, necessitated changes in the structure of the Rate Setting Bureau.

A Hospital Rate Setting Bureau and a Nursing Home Rate Setting Bureau were formed, each handling its own appeals. Criteria for appealing and guidelines for the processing and timing of the appeals are delineated in Part 86 of the NYSDH's rules and regulations.

---

[1]As of the end of 1978, approximately 2400 appeals were settled. Furthermore, the NYSDH expected that as of July 1979 all past appeals would be cleared, and the NYSDH would be operating on its current workload.

One possible ground for appeal is the discovery of an error made in the rate computation process or in the submission by a medical facility, which must be brought to the attention of the Commissioner within 120 and 60 days, respectively. These mathematical errors may be handled over the telephone; to date, over 300 such appeals have been taken care of through the Department of Health's special "rate-setting hotline."

Other criteria for appealing include:

- requests for revisions in a hospital's base-year rates due to cost increases incurred prior to the determination of its current-year rates;

- significant increases in the overall operating costs of a facility resulting from the implementation of new or additional programs, staff, or services as well as capital renovation, expansion, or replacement of the facility specifically mandated by the Commissioner;

- requests for waivers of any provisions of Part 86;

- changes in the hospital's method of providing services, which result in a higher overall cost for the services provided; and

- requests for relief from the ceiling and/or grouping provisions of Part 86. For such relief, the facility must demonstrate that its range of approved services, patient mix, or other patient factors are direct causes for all or part of the costs in excess of the ceilings.

A format has been developed by the Rate Setting Bureau and is now being followed by all hospitals requesting departmental reviews of their certified rates. An application for a review is submitted to the analysts on a form provided by the Department, on which the facility completes a paragraph stating the reasons and factual basis for the review and then attaches any appropriate documentation. The Department may request additional documentation for items determined to be necessary. The Bureau's response is then added to the form. No specific item in the regulations places any restraints on the timing of answering these appeals; however, it is a matter of Department policy to handle them within ninety days of receipt. The completed document is reviewed by the Commissioner of Health and then passed on to the Budget Director for his approval of the

revised rate. Changes in Blue Cross rates must also be approved by the Superintendent of Insurance. The provider is notified by mail of the amended rate.

The medical facility may reappeal to the NYSDH within thirty days of receiving its rate and request an administrative hearing. Although very few hospitals have reappealed to the Department, a very detailed protocol has been developed and must again be followed by the hospital. Another form stating the factual issues to be resolved must be submitted along with memoranda on any legal issues that the hospital deems relevant to the appeal. The Hearing Officer, who is an attorney from the Office of the Council to OHSM, then reviews the application for a hearing. If the officer determines that there is no factual basis for a re-review, the request is denied. The facility is notified of this determination and no further administrative appeals are available to it.

If the rate review officer determines that there is a factual issue to be considered, he issues a hearing notice, which establishes the date, time and place of the hearing and restates the factual basis for it. All administrative hearings are held in conformity with the provisions of the New York State Public Health Law and Administrative Procedures Act. The hospital and its attorney, plus the rate setters and their attorney, appear before the Hearing Officer and present their cases. The subsequent decision is rendered on the merits of the case. Issues of fact, not the law, are the basis for the judgment. The rate review officer's recommendation is submitted to the Commissioner of Health for final approval or disapproval and recertification of the rate, where appropriate.

Any modifications in the rate are put into effect on the first day of the month beginning thirty days after the Bureau receives the hospital's request and justification for a hearing. This is a new procedure that has been developed by the Rate Setting Bureau; hospitals have yet to take advantage of it. However, it is still the case that once this hearing has been completed, any hospital that remains dissatisfied may appeal to the courts to hear its case.

Litigation

While the NYSDH has been virtually inundated by the sheer number of appeals it has received, the length and cost of the court cases in which it has been involved are what has really impeded the Department over time. Most individual rate adjustments are settled out of court, but massive class action suits have tied up final rate settlements in the past several years. As the rate review process has become more stringent, the complexity and number of cases have increased, each potentially precedent setting in its own right. Synopses of several of the large and more controversial court cases brought against the NYSDH follow.

Federal regulations in 1967 required that Medicaid inpatient service payments be computed according to the Medicare program's "reasonable cost" retrospective principles. New York State, in an attempt to comply with these guidelines, adopted retrospectivity. As a result, costs of the Medicaid program skyrocketed. In 1968 and 1969, the state reduced Medicaid eligibility levels severely, trying to restrain the runaway costs of the Title XIX program. An amendment was enacted by the legislature which froze hospital rates for Medicaid patients from March of 1969 until December 31, 1971. The resulting uproar persuaded the legislature to remove the last two years of the freeze. The initial nine months of the freeze were eventually overturned by court action. In this case, Catholic Medical Center of Brooklyn and Queens, along with several other hospitals, filed a class action suit against then Governor Nelson A. Rockefeller and various state officials challenging New York's authority to freeze hospital rates. The Appellate Court overturned the freeze on the grounds that it did not conform with federal rate-setting regulations. The state appealed to the U.S. Supreme Court, but the Court would not hear the case. The Appellate judge ordered the state to reimburse costs to the hospitals for this period. The repayment was detained for several years as the state and the hospitals argued over how best to comply with the Court's decision.

During 1973 and 1974, the court heard a case by the Hospital Association against the State of New York's implementation of the federal ESP program. The state had used the "class of purchaser" approach in establishing hospital rates for the year; that is, New York had allowed a six percent rise across all providers. The hospitals felt that each provider should be allowed to argue its own case for a rate increase; one provider could possibly justify a ten percent increase, while another, only two percent. This would then average out to the desired six percent increase. The court decided against HANYS in this case and ruled that the state did have the power to grant a uniform, across-the-board increase to all hospitals.

Another case filed in 1974, this time by Long Island College Hospital, challenged the state's disallowance of legal fees as reimbursable costs. The Stein and the Moreland Commissions, along with other state officials, made a series of recommendations to the rate setters regarding legal fees. They felt that the state was paying for hospitals and nursing homes to take them to court. There was no ceiling on these costs, and they advised rate setters that these fees should be disallowed. Long Island Hospital and others felt that the state was encroaching on their right to sue and took the case to court. New York tried to set up a program whereby the

hospital, if it won its case and indeed showed the state to be in the wrong, would be reimbursed for the legal costs it had incurred. The question of partial judgments arose, however, and the program was never initiated. To this day, the case has never been settled and hospitals are still being reimbursed for all legal fees.

The largest case in which the state of New York has been involved, and the one with the greatest potential ramifications, is the case begun in 1976 by the Hospital Association of New York State versus Phillip Toia, then head of the Department of Social Services. At the end of 1975, the state announced that it would change the formula under which reimbursement was being calculated. Rate-setting officials intended to go to the legislature for approval of their plan, but until such approval could be obtained, they planned to freeze Medicaid rates. They proposed to amend the formula to drop inpatient routine allowable costs from 110 to 100 percent of the group means, to disallow ten percent of interns' and residents' salaries as costs of education (education being a nonreimbursable cost), and to make some other minor changes. Upon receiving notice of these changes in April, 1976, HANYS promptly filed suit in the federal court of the southern district challenging the freeze.

In June, 1976 the state announced that it had secured the appropriate legislation and regulations and had calculated new rates for all hospitals. Due to the time it had taken to get the necessary regulations approved and the new rates computed, the state did not issue the amended per diems until June 30, but applied them retroactively to January 1, 1976.

HANYS amended its suit, since these changes now superseded the freeze. The Association challenged the concept of the 100 percent ceiling, as well as the disallowance of interns' and residents' salaries and the other changes. There was also an important procedural challenge: the Department of Health, Education and Welfare had yet to approve the revised formula. By law, such approval was necessary before the state could implement any changes. HANYS asked Judge Lasker, who was hearing the case, for preliminary relief, and the judge agreed. The state was enjoined from implementing the new rates until DHEW approved the modified formula. He also ruled that the hospitals were to be reimbursed at their 1975 rates trended upward. This sum amounted to approximately $40 million owed to the hospitals since the first of the year.

On August 16, 1976, DHEW approved most of the formula changes. The ten percent disallowance for interns' and residents' salaries was approved in October. HANYS amended its suit again to focus on the merits of the plan as approved by federal officials. The Hospital Association felt the approval to be invalid and illegal under federal law and asked the court to rule the system invalid and disallow its use by the state. The state, unsure of how best to defend itself against the HANYS claims, put off any action on the case.

Finally, in December, the state retained a private law firm from Washington, D.C., to handle its case. With the state in danger of being held in contempt of court for not reimbursing the money owed the hospitals, the attorneys urged the rate setters to immediately recompute the hospitals' per diems as the judge had instructed. From January 1 until August 16, 1976, the day DHEW approval was received, rates were trended upward from the 1975 formula. After August 16, the state was free to reimburse hospitals under the new guidelines. Thus, the $40 million figure became a fixed sum of money; further litigation would have no impact on the amount of money being contested. The trial was then postponed again until March 1977 to allow the new attorneys for New York to prepare their case.

A new wrinkle then appeared in the state's case. Late in the 1975 session of the U.S. Congress, a law was passed that required states, insofar as hospital rates for federal patients were concerned, to waive their immunity from suits in federal courts. (The Eleventh Amendment to the U.S. Constitution prohibits federal courts from issuing money judgments against states.) Thus states were forced to consent to be sued in federal courts or lose ten percent of their federal Medicaid funds. This new law is what allowed the $40 million judgment to be handed down against New York State, over its protestations, in the first place. In October 1976, Congress repealed the law, retroactive to the day it became effective in 1975.

The State of New York, claiming the federal court now had no jurisdiction in this matter, asked Judge Lasker to withdraw the $40 million decision. The case went to the Court of Appeals, which ruled in favor of the state. Saying that Congress had intended to undo situations such as this one in New York when it repealed the law, the court ordered Judge Lasker to ask for the money back from the hospitals. HANYS filed two suits in state courts in an effort to block the return of the money, but lost its case at both the lower and intermediate state court levels. As of July 1, 1979, the hospitals were to begin repaying the $40 million to the State of New York. Further appeals may be launched.

The state again changed the rate-setting formula in April 1977. DHEW approved those changes which modified the groupings into which hospitals are placed for routine and ancillary inpatient costs and the resultant 100 percent of the mean ceilings. Also, a length of stay penalty was added. These changes had a strong impact on hospital rates. Therefore, the state's attorneys felt justified in going before Judge Lasker and asking him to dismiss the case regarding the 1976 formula, since the amended formula was now in effect. With the repeal of the 1975 law, the federal court could not grant reparations for past damages but could only enjoin the state from future actions. The state, therefore, asked the judge to have the hospitals litigate the "current plan." HANYS, however, preferred to litigate the 1976 formula and refused to amend its case. Judge Lasker

dismissed the case of the 1976 formula, saying that the 1977 plan had superseded it, even if the 1976 plan had been illegal. Because the hospitals refused to litigate the 1977 formula, he dismissed that case as well.

DHEW, which had been named as one of the original defendants in the 1976 suit, now took on new importance in the case. Judge Lasker, in dismissing the State of New York from the case, did not dismiss DHEW as well. He felt that the court could still rule on the validity of the original DHEW approval; the DHEW approval process is an "important and continuous" activity and as such, could have impact on the "future." Therefore, grounds for an injunction could be found, and the judge could order the process amended and improved. Judge Lasker ordered the question brought before the court. The trial was completed in December 1977. Briefing of the case concluded in June 1978, and a decision was recently rendered. The judge dismissed the case, challenging the appropriateness of the plan itself. He ruled that the main body of amendments that were approved in August of 1976 were done so in an appropriate manner. However, he held that DHEW approval of the ten percent disallowance for interns' and residents' salaries as educational costs was invalid on the grounds that DHEW did not have sufficient evidence to set the level at the ten percent figure. A final judgment has yet to be filed. When Judge Lasker does complete his statement, the hospitals and/or the state will have 60 days in which to request a further appeal.

After the 1977 changes were made, two new suits were filed challenging provisions that the hospitals did not like, specifically the length of stay penalty and the "level of care provision." The latter provision was never implemented and is now a moot point.

The first case was filed in New York State Court as Brooklyn Hospital versus Whalen. Late in the year, the Health and Hospitals Corporation of New York City filed a suit in Federal Court against state officials and the DHEW regarding these changes in the regulations.

As this case was being filed, the 1978 changes in the regulations were promulgated. The 1977 length of stay penalty was very severe for inefficient hospitals, and, as a result, they incurred tremendous penalties. The 1978 regulations modified and lessened the severity of the length of stay penalty; only medical and surgical patients were included in the calculation of the average length of stay penalty, rather than all patients. By leaving out maternity and some other patients, the penalties were reduced. Combined with refinements in the grouping mechanism, the new system is easily defensible in the eyes of state officials. The state went before Judge Duffy, who is hearing this case, and asked him to dismiss the 1977 case and rule only on the 1978 case on grounds similar to those allowing

the dismissal of the 1976 case by Judge Lasker. The Health and Hospitals Corporation has amended its suit to challenge both the 1977 and 1978 rates. Judge Duffy, who has been informed of Judge Lasker's ruling, has yet to rule on this motion.

The state does not intend to dismiss every year's regulations as the next year's regulations are created. It feels that if substantial changes occur, the previous case should be dismissed. If no major changes result from the new guidelines' being established, then the state is willing to keep the old case in court and to defend its position.

The litigation to date has been lengthy and costly. Several cases are still pending in federal and state courts, and there are more cases to come. The question of the $40 million has yet to be argued on the merits of the formula that was established. The state, anticipating an action on this point, maintains that gross inefficiencies exist within hospital management and that approval of the formula, albeit late, is still approval. There is not likely to be a quick and easy resolution of these or any of the aforementioned points in these cases.

Program Cost

Because of the several entities involved in setting the rates in New York State,[1] as well as the continued changes in the system over time, estimating a reliable program cost figure is extremely difficult. However, the Office of Health Systems Management in the NYSDH has provided some data on program expenditures dating from fiscal 1971. The figures provided reflect both hospital and nursing home rate setting; therefore, estimates of program cost per facility rather than per hospital have been made. Also, the state contracts with the various Blue Cross plans to perform audit, edit, and investigative functions, but these functions would be carried out in the absence of a prospective system as well. Therefore, their exclusion is appropriate.

Table 5 lists the number of personnel for fiscal years 1971 through 1978, expenses (by natural classification), total facilities, and expense per facility for the rate-setting program in New York State. Unfortunately, data-processing costs for the years prior to 1978 were unavailable, so the per-facility costs for those years are biased downward. From 1971 to 1978, personnel in the rate-setting program increased from thirty-five full-time equivalents to eighty-nine full-time equivalents, an increase of approximately 150 percent, or 22 percent per year. Expense per facility

[1]Several bureaus within the Office of Health Systems Management, Downstate Blue Cross and the seven Upstate Blue Cross plans. There are also costs (e.g., forms preparation, consultant fees, legal fees) to other groups, such as the Hospital Association and individual hospitals.

TABLE 5: Rate-Setting Personnel and Expenses, Fiscal Years 1971 to 1978

YEAR	EXPENSE CATEGORIES							TOTAL EXPENSE	Total Non-Federal, Non-Psychiatric Hospitals	Total SNFs and ICFs	Total Facilities	EXPENSE PER FACILITY
	Number of Personnel	Personnel Salaries	Supplies	Travel	Contractual	Equipment	Data Processing					
FY 1971	NA	$ 356,663	$ 1,866	$ 3,962	$ 1,231	$ 261	NA	$ 363,983	363	752	1,115	$ 326
FY 1972	35	$ 399,386	$ 1,145	$ 3,693	$ 2,495	$ 1,420	NA	$ 408,139	353	746	1,099	$ 371
FY 1973	35	$ 430,059	$ 1,768	$ 4,152	$ 1,411	$ 5,264	NA	$ 442,654	352	601	953	$ 464
FY 1974	35	$ 500,996	$ 1,544	$ 8,353	$ 3,367	$ 0	NA	$ 514,260	350	797	1,147	$ 448
FY 1975	43	$ 616,519	$ 2,414	$ 6,545	$ 3,282	$ 9,740	NA	$ 638,500	342	804	1,146	$ 557
FY 1976	51	$ 749,014	$ 4,604	$ 6,015	$ 3,897	$ 1,873	NA	$ 765,403	332	779	1,111	$ 689
FY 1977	89	$1,058,322	$14,426	$21,060	$32,384	$47,110	NA	$1,173,302	319	784	1,103	$1,064
FY 1978	89	$1,423,114	$ 6,619	$41,210	$66,580	$39,305	$107,897	$1,684,725	310	782	1,092	$1,543

Note: Figures do not include contracts to Blue Cross for audit and edit functions.

increased from $326 per facility in 1971 to $1,543 per facility in 1978, an increase of almost 400 percent, or 53 percent per year. This percentage increase, however, is biased upward due to the lack of data-processing expenses in the early years. These figures imply that the rate-setting program would have to result in a savings of $1.7 million (for hospitals and long-term care facilities) in order to be cost-effective, at least for fiscal 1978.[1]

Developmental Efforts

There have been several developmental and experimental efforts underway in the state of New York over the last several years. These efforts have stemmed from Medicaid, Blue Cross, the industry, and the legislature, and involve anywhere from one hospital to all hospitals in the state. They are described below.

Incorporation of Case-Mix Considerations into the Appeals Program

In 1977 and early 1978, the NYSDH faced a backlog of 214 appeals on ceiling disallowances based on case-mix considerations. The Department thus, of necessity, developed a methodology to deal with case-mix differences within the appeals process. In order to do this, a large secondary data base of discharge (diagnostic) data was assembled, utilizing data from: the Professional Activities Survey (PAS) data base maintained by the Council on Professional Hospital Activities (CPHA), the Uniform Information System (UIS) data base maintained by the Hospital Association of New York State, the several independent computerized systems maintained by some of the large teaching hospitals, and ten percent discharge samples taken from those hospitals that maintained manual systems. Borrowing from the Maryland data system, which links charge information to 383 Discharge Related Groups (DRGs), New York developed a relative value for each DRG in order to rank them in terms of complexity. Each hospital was then compared to its group average along three dimensions: a DRG-weighted index for patient days, a DRG-weighted index for discharges, and a case-mix adjusted length of stay. The degree of difference indicated between the hospital's indices and the group's overall indices was then applied to the penalties that had been assessed on routine costs, ancillary costs, and length of stay and returned to the hospital. For instance, if the hospital's DRG-weighted index for patient days indicated that the hospital had a twenty percent more complex case mix, then twenty percent of the penalty disallowance on routine cost per diem was reinstated into the hospital's rate.

---

[1]The $1.7 million necessary savings may be an underestimate, since there are other program costs (Downstate Blue Cross data [UFR] processing costs, costs to providers, etc.) that are not measured here.

Budget Review

There is one hospital in New York, Albany Medical Center, that is currently on an experimental budget review system. While Medicaid continues to reimburse the hospital via its formula methodology, Blue Cross has reviewed the hospital's budgeted costs for 1978 and set a Blue Cross per diem based on the budget. In 1979 and 1980, a cap on revenues will be set based on the trend factor; that is, 1978 revenues will be multiplied by the trend factor, and the result will be a cap on 1979 revenues that the hospital is allowed to generate.

The Northeastern New York Blue Cross Hospital Experimental Reimbursement Study

This experimental reimbursement system will be open to all member hospitals of the Albany Blue Cross Plan in January 1980 and will continue for three years. Individual facilities' 1980 revenue will be projected from 1978 costs. This 1980 revenue will be trended forward each of the remaining years, so that costs will no longer impact on revenue. Retroactive adjustments on a per-discharge basis will be made for volume changes, case mix, and inflation. Total reimbursement will also be affected by the facility's productivity and efficiency.

The Crouse-Irving Memorial Hospital Experiment

This experiment involves one hospital and will represent a flat per-case payment by either the DRG classification or some alternative diagnostic classification. The stated incentive of the experiment is to reduce length of stay.

The Minicap Program

The Minicap program is a two-year effort beginning in 1979 that will lead into the Maxicap program described below. The program involves about seven or eight hospitals in the Rochester Hospital Corporation. Under this program, 1978 rates will be trended to 1979, and then each payor will pay a portion of projected revenue. There will be an adjustment technique for changes in payor mix. While the hospital may keep any savings it realizes through increased productivity, it is at risk if expenditures exceed the allowable rates.

The Maxicap Program

This experiment is still in its developmental stage and is being funded through the Health Care Financing Administration (HCFA). It involves the twenty-four Rochester Hospital Corporation hospitals and is based on the concept of an area-wide cap on total hospital expenditures. Planning groups and the hospitals are directly linked to the program, and, using planning

techniques, they will allocate the agreed-upon Maxicap (total allowable expenditures for the area) among the various hospitals. This program will not be operational until 1980.

INTERACTIONS

Legislature

Given the history of cost control legislation in New York State, which began early and has become increasingly stringent over the years, it seems clear that the Department of Health has had strong support from the state legislature. Although at the time of the site visit it was not possible to ascertain the exact nature of the interaction between the Office of Health Systems Management and the legislature, it would appear that the legislature has been quite receptive to incorporating new, more constraining authority into the Cost Containment Act. Furthermore, the former director of the rate-setting program currently serves as Director of Staff for the Health Care Financing Council, which is chaired by the Chairman of the Senate Health Committee. This link between the former rate-setting director and the legislature should act at a minimum to facilitate information flow and may very well serve as a catalyst for informed policymaking to deal with the problems of the industry.

Hospital Association of New York State

The Hospital Association of New York State (HANYS) clearly works toward increasing reimbursement for its member hospitals. While HANYS is involved in improving the quality of delivery of health services, over 50 percent of its staff's time is spent on reimbursement issues alone. To this end, the Association has developed a large fee-for-service (management and planning services) division, legal and economic research staffs, and a lobbying group.

The fee-for-service group helps hospitals prepare their appeals to the Rate Setting Bureaus. If problems develop that tie up the rate review process, the Hospital Association will again intercede on behalf of the hospital involved. Memos are routinely sent to the NYSDH and pressure is applied on the legislature to get the reviews on track. The Hospital Review and Planning Council may also be asked to take action.

For problems that are more general to all or several of the hospitals in the state, HANYS again takes the lead. The many class action suits that have been filed against New York State have, for the most part, been led by the Hospital Association. These cases include the suit against the 1974 freeze of Medicaid rates and the case that is currently in litigation challenging the legality of the rate review guidelines from 1976 to the

present. Both cases, and HANYS's involvement in them, have been detailed in the Litigation section of this report.

The staff of the Association has grown over the past several years; one of the areas that has expanded the most has been the government relations office. The lobbying group is now up to five full-time positions. Most of their time is devoted to lobbying Congress on matters of national health policy. Four-fifths of the lobbyists' time is spend on hospital issues with the remainder spent on nursing home problems.

HANYS feels very strongly that the rate-setting program has not always been fair to hospitals, that cash flow problems in some hospitals are due to the drawn-out rate review process, and that endowments have been eroded. Catchment areas for hospitals have been changing, and the formula does not incorporate these changes in terms of patient or case mix. The Association feels it is inequitable for a hospital that had a high base year to be allowed to perpetuate this advantage or for hospitals to be allowed to manipulate their groupings. It also feels that the overwhelming backlog in appeals at the beginning of 1978 has hurt the hospitals financially and that lags in the Article 28 Certificate of Need program have allowed inflation to dissipate the originally estimated construction costs.

The Association has responded to one of these problem areas by helping the hospitals develop their ability to estimate rates, and hospital controllers have become very proficient at this process. Although the rates often turn out to be higher than first anticipated, these more conservative approximations have alleviated many of the serious consequences that have resulted in the past from delays in the rate-review process.

In terms of interaction historically, HANYS has been involved from the beginning in the formation of the prospective reimbursement system in New York. Prior to 1970, no significant cost containment program was in place; however, there was a retrospective regulation process between Blue Cross and the hospitals. This was essentially a "cost-plus" contract arrangement.

In 1968, HANYS supported a "Ghetto Medicine" bill, which provided for reimbursement of outpatient services for the working poor in New York City. When a hospital applied to become a member of the ghetto medicine program, a sliding fee schedule was developed, which was paid with matching funds from the state and the City of New York. The city fell behind in its payments and the state, by law, could match city money only. To keep the program afloat, the state in 1973 received the right to match private philanthropic funds as well.

HANYS sponsored legislation in 1974 providing that all payors participate on a pro rata basis in absorbing bad debts resulting from outpatient services. This legislation was an outgrowth of a Blue Cross decrease in its Community Service Factor and the subsequent need for another method of collecting bad debts. The program was not enacted federally, so at that point, Blue Cross was still the only payor picking up a share of bad debts. The Association also wrote and lobbied for a 1974 statute mandating that the state issue per diem rates sixty days in advance of their implementation. Another bill was passed that allowed outpatient deficits to be included in inpatient per diem costs.

Since 1976, the Association has been very effective in mitigating the effects of changes in budget bills. In that year, the state wanted to freeze hospital outpatient rates, but HANYS lobbied to obtain a five percent increase. The state also tried to disallow twenty percent of house staff salaries as well as a list of elective surgical procedures. Administrative approval by the Review and Planning Council was not granted. HANYS did support a program to decertify unnecessary hospital and nursing home beds in that year.

In 1978, the Governor proposed a statewide ceiling on capital expenditures. HANYS did not oppose the idea of a state cap, but rather the planned implementation program for it. The ceiling is now being considered as a demonstration project by the State Hospital Review and Planning Council.

HANYS has now begun work on its 1979 goals. It is lobbying for a $10 increase in the outpatient visit rate cap from $50 to $60. Feeling that the state has been holding back millions of dollars, the Association also wants an outside controller to audit the Department's process for establishing previous trend factors to insure that the state has not been "massaging" them.

The workmen's compensation laws will also come under fire this year. Workmen's compensation does not classify hospitals as providers of services, except on an outpatient basis; it will pay doctors for inpatient continuing services only when an injured worker is admitted to the hospital after emergency room care. Blue Cross must pick up the remainder of the patient's bill. HANYS wants the hospitals to be designated as providers so that the workmen's compensation rate (which is a cost-based, negotiated rate that is higher than the Blue Cross rate) will be paid in these cases.

The Association has been lobbying for the formation of an independent rate-setting commission since 1976. HANYS objected to the inherent conflict of interest situation that exists with the Department of Health, as a major purchaser of hospital services, setting the price for these

services. The Association introduced a bill to administer planning, standard setting, and reimbursement under a single commission, thus integrating all health regulatory activities. At the time of the bill's introduction, it was felt that the hospitals would have granted the state control over charges in exchange for getting an "objective outside group involved." The bill never passed; Governor Carey was strongly opposed to relinquishing public responsibility for monitoring health care, especially since several other commissions, such as the Triboro Bridge and Transit Authorities, were under fire at the same time. In 1977, HANYS proposed placing only the rate-setting responsibilities under the commission structure. For many of the same reasons, the bill still did not pass.

The Hospital Association of New York State continues to push for the abandonment of the per diem rate-setting process and the adoption of a budget review system under an independent commission. Recognizing the uphill struggle it faces, the Association would be willing to settle for a change in the system failing a change in the authority governing it. HANYS sees this situation--the dissipation of the executive branch of the state government and the creation of more and more "advisory" groups--as conducive to the eventual formation of such a commission.

Planning

Concerned about the adverse effects that the unplanned development of health services facilities had had upon the cost and quality of health care in New York State, in 1964 the Governor appointed a Committee on Hospital Costs to study the situation extensively. The "Folsom Committee" report contained over fifty recommendations for reducing hospital costs, maintaining or improving the quality of care, and eliminating duplication of services. At about the same time, the Metcalf-McCloskey Act was passed, which required that the establishment of new hospitals in the state be approved by the state Board of Social Welfare with the advice and consent of the Department of Health, a statewide Hospital Planning Council, and seven local Regional Planning Councils.

Following the report of the Folsom Committee, legislation was enacted in 1965 that expanded upon the authority of the Metcalf-McCloskey Act. Article 28 of the state public health law gave broad health facility planning powers to the Department of Health. Subsequent complementary enactments in 1966, 1968 and 1969 authorized a total of almost $4 billion in low-cost loans to construct or modernize nonprofit hospitals, nursing homes, and intermediate care facilities. This, it was felt, would balance the planning controls with implementation incentives of increased capital funding for facilities. The program was suspended in April 1975 due to the bond market crisis during New York's fiscal crunch.

In compliance with PL 93-641 of 1974, New York State designated the existing state Health Planning Commission (HPC) as the State Health Planning and Development Agency (SHPDA) (see Figure 5). HPC is composed of the commissioners of the various state health agencies. Its staff is augmented by personnel in OHSM's Division of Health Care Planning and Resource Management. As the SHPDA, it is obligated to prepare a preliminary state health plan developed from health systems plans submitted by all the Health Systems Agencies (HSAs) in New York. (The HSAs are outgrowths of the previous Comprehensive Health Planning Agencies that were formed under the original Article 28 guidelines.) This preliminary plan is then submitted to the State Health Coordinating Council (SHCC) for its approval and to the Secretary of HEW for final approval.

The second plan the SHPDA must develop is the Medical Facilities Plan, which inventories the existing medical facilities in the state, the number and type of medical facilities and beds necessary for adequate inpatient and outpatient care, and other medical facilities needed to provide overall adequate care. The SHPDA must review and modify the plan at least annually. This plan, too, must be approved by the SHCC and the Secretary of HEW. PL 93-641 further mandates the SHPDA to conduct appropriateness reviews of the medical facilities in the state at least once every five years.

The SHCC is a group of twenty-eight members, sixteen of whom are nominated by the eight HSAs in the state and approved by the Governor; the other twelve are appointed directly by the Governor. Appointments to the SHCC have resulted in equal representation of consumers and providers. The SHCC must annually review and coordinate the Health Systems Plan and the Area Implementation Plan of each HSA in the state and comment on them to HEW. Similarly, the SHCC must review all HSA budgets annually and send along its comments to HEW. Although the SHCC has the final authority to make the state plans, it has no authority at all to implement them. This power rests squarely in the SHPDA and the state's Department of Health; in fact, most of the SHCC's staff work is done by Department of Health personnel.

PL 93-641 also mandates the formation of a "Certificate of Need" (CON) program in each state. Although PL 93-641 authorizes the SHPDA to administer CON, the process already was being handled by the state Department of Health and the Hospital Review and Planning Council, and New York had no intention of moving this responsibility to the HPC. In fact, the HPC has delegated some of its CON authority back to other agencies in OHSM.

The CON process in New York is long and complicated (see Figure 6). A facility submits its application to a regional office of the state Department of Health. The regional office then distributes copies of the application to the HSA in its area and to the Project Control Unit (PCU) in OHSM's

Figure 5
RELATIONSHIP BETWEEN PLANNING AND OFFICE OF HEALTH SYSTEMS MANAGEMENT

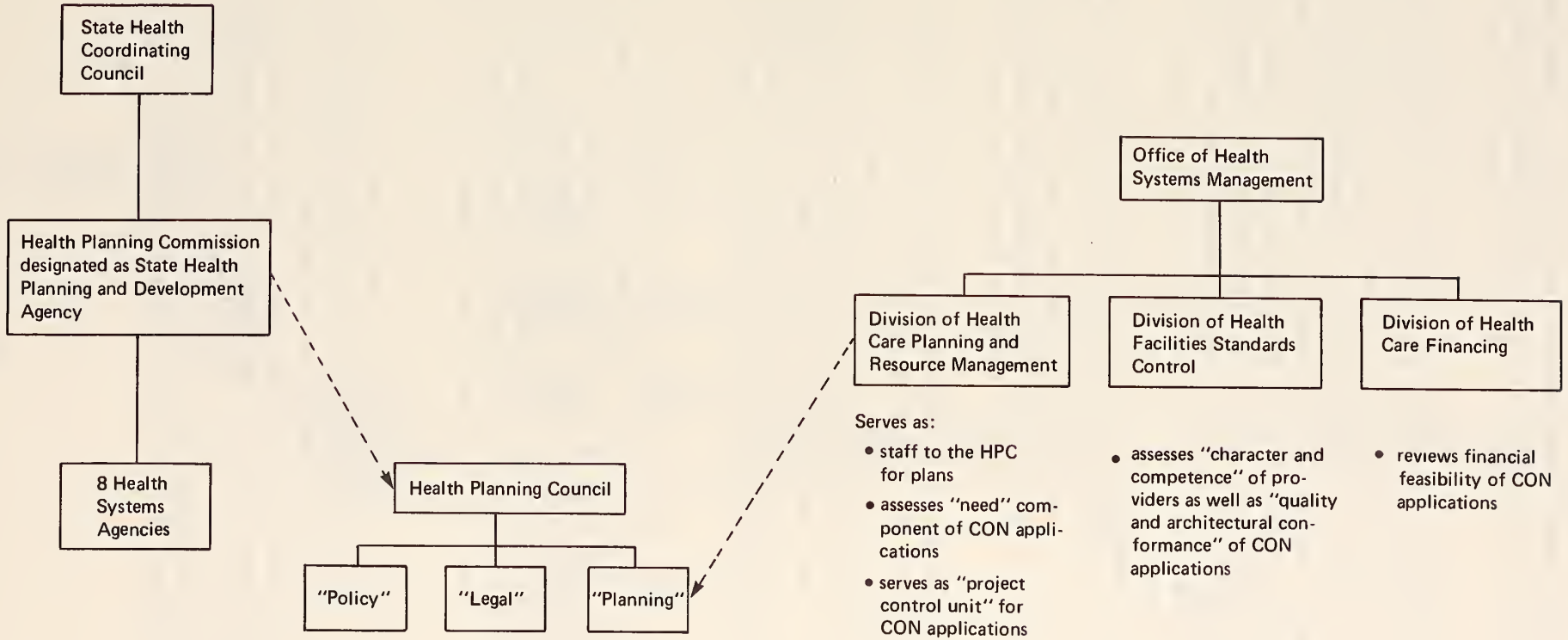
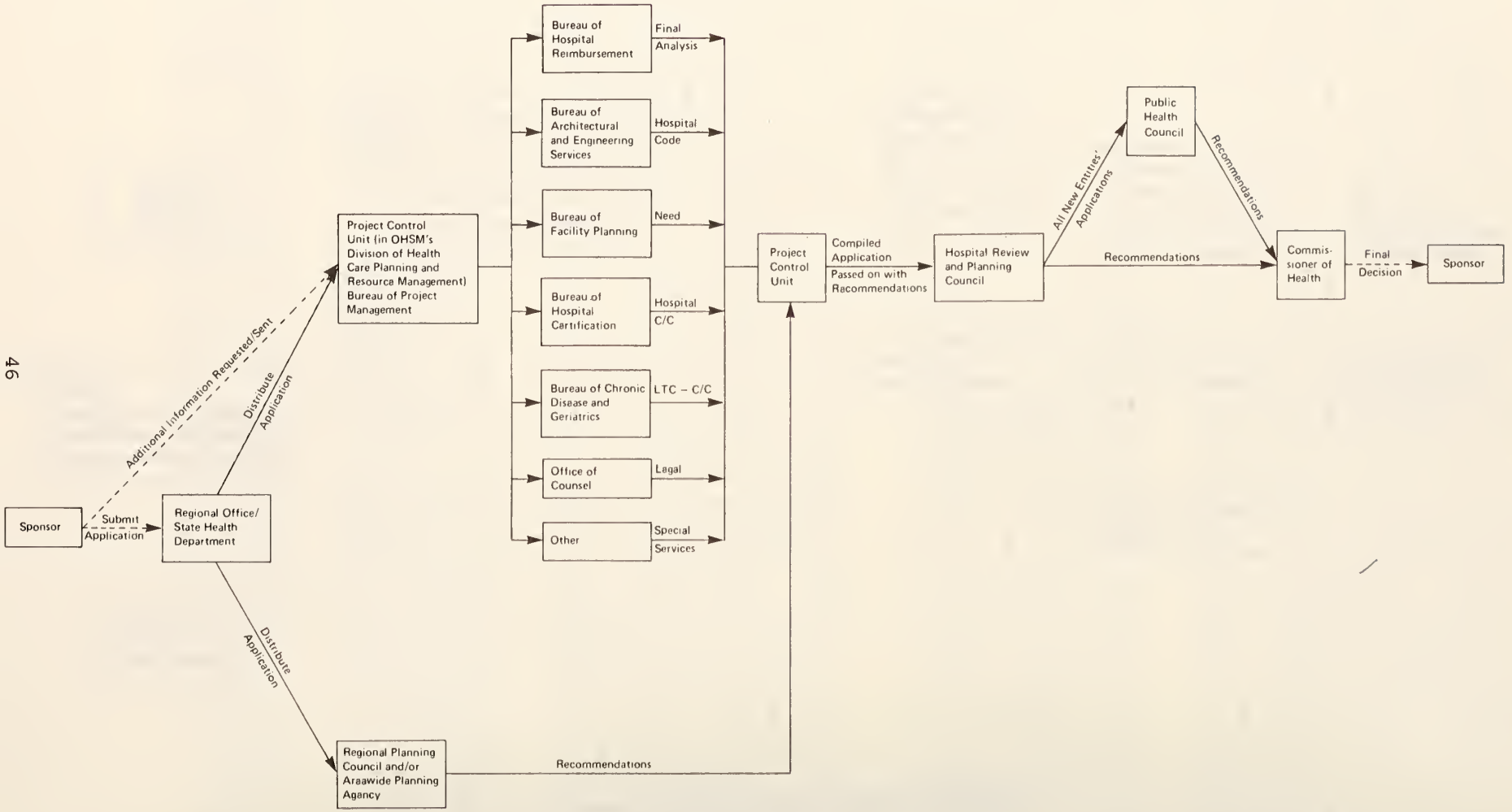

State Health Coordinating Council
Health Planning Commission designated as State Health Planning and Development Agency
8 Health Systems Agencies
Health Planning Council
"Policy"
"Legal"
"Planning"
Office of Health Systems Management
Division of Health Care Planning and Resource Management
Division of Health Facilities Standards Control
Division of Health Care Financing
Serves as:
• staff to the HPC for plans
• assesses "need" component of CON applications
• serves as "project control unit" for CON applications
• assesses "character and competence" of providers as well as "quality and architectural conformance" of CON applications
• reviews financial feasibility of CON applications

Figure 6
FLOWCHART OF NEW YORK STATE'S CERTIFICATE OF NEED PROCESS



Note: Parts of the flowchart were taken from a similar chart in the New York State Department of Health's Bureau of Facility Planning *Policies and Procedure Manual, 1977.*

Bureau of Project Management within the Division of Health Care Planning and Resource Management. The PCU may request additional information from the facility before it sends copies of the application to various bureaus within OHSM for their consideration.

Need determinations are done by the staff of the Bureau of Facility Planning. Responsibility for financial feasibility studies has been shifted to the Financial Analysis unit within the Division of Health Care Planning and Resource Management. Character and competence reviews of CON projects are handled by the Facility Surveillance Group. These three major components of the CON reviews are handled in the three different divisions of OHSM and are brought together along with other bureau inputs and the HSA report of the PCU. The completed application and recommendations are then sent along to the Hospital Review and Planning Council for its consideration.

Prior approval by the gubernatorially appointed State Public Health Council is also required before any new health facility may be established. The Public Health Council again assesses the need for, and the competence, character, and cost of, the proposed new service before offering its recommendations to the Commissioner of Health.

Proposed changes in the structural capacity or procedures of an existing facility, as well as construction of any new facility, must have the approval of the Commissioner of Health. Should the proposed changes be disallowed, the sponsor has recourse to a public hearing held before an independent hearing officer appointed by the Commissioner. The sponsor and the HSA staff present their evaluation and justifications for consideration. If the facility is still displeased by the hearing officer's finding, it may appeal to the courts.

Appeals are granted at other levels as well. The state Review and Planning Council provides the HSA with the opportunity for a hearing whenever the Council's recommendation is at odds with the Agency's opinion. Finally, the Public Health Council will conduct a public hearing whenever it intends to act contrary to a recommendation received from an HSA about construction of a new facility. If the Public Health Council intends to reject a proposal, it will extend the option of a hearing to the sponsor as well.

In 1967, the CON program in New York State was rapidly expanding, and this growth continued until the 1975 financial crisis. At that point, building programs were constrained for almost three years, yet the influence of the planners on rate-setting policies continued to increase. Recently, the CON mandate has been growing, although not de jure under the written regulations governing the program. Three specific goals have been focused upon during this expansion: decreasing excess capacity, decreasing lengths of stay and other utilization factors through financial incentives, and cost containment.

During 1979, other changes are being enacted to further streamline the CON process: decreasing paperwork and implementing new criteria. In an attempt to prioritize capital investments within regions and the state, "batching" of CON applications, a method of comparative analysis, is being put into effect. Hospital expansion proposals will be considered by area; they will be reviewed for their relative need and importance to the area, and the money that has been allotted to the region for facility growth will be divided accordingly.

Need determinations by personnel in the Division of Health Planning are done not only for the CON program but for any regionalization or merger program in the state. Hospitals volunteering for the Hospital Closure Incentive Program or the Hospital Conversion Incentive Program must be cleared by the planners before the rate setters will proceed. The same is true for hospitals applying to the Emergency Relief Program for immediate financial assistance; they must be screened by the planning staff and certified as necessary to their surrounding neighborhoods.

The Bureau of Capital Cost Financing (BCCF) previously had responsibility for assessing the capital cost component of a hospital's daily rate. It interfaced with the CON program on financial feasibility studies for proposed construction or expansion of services projects and relied on the program to implement a ceiling on capital expenditures. The BCCF was disbanded recently, and its responsibilities were assumed by other bureaus within the Division of Health Care Planning and Resource Management.

Four bureaus were involved in the process. The state Mortgaging Authority, which handled the old New York State board program for hospital construction, was virtually suspended due to the 1975 financial crisis, but may be in operation again soon. The Financial Analysis Unit handles all CON financial feasibility studies and the facility's daily rate. It has been moved to the Planning Division. Capital budgets for every project are formulated by the Construction Cost Control Unit, temporarily located in the Bureau of Hospital Reimbursement. This unit, along with other professionals (architects, etc.), estimates the reasonable cost of the "idea" of a project and sends its report to the Planning Division. The fourth unit is Capital Reimbursement, which deals with the actual additional reimbursement figure for all hospital and long-term care facilities. Its functions have been divided between the bureaus of Hospital Reimbursement and Long-Term Care Rate Setting. The capital reimbursement system is quite piecemeal. In response to the nursing home scandal, changes have been occurring rapidly, and these modifications in capital financing usually find their way, with more changes, to the acute-care hospital sector.

Construction and expansion of nursing homes continued unchecked until 1975, when reimbursement for new services was disallowed unless the facility had a prior approval for its capital investment. The program was nominally enforced in acute-care hospitals until 1977. A revised reporting format has boosted the effectiveness of these controls.

Rate setters and planners, however, still have difficulty in controlling smaller projects (i.e., less than $100,000). For projects under the $100,000 ceiling, hospitals can expand at will, buying new equipment or other items from their debt service and absorbing the cost for two years. Two years later, the cost is assumed as a depreciation expense. As long as the hospital can maintain expenses for two years, the project is permitted untouched and unauthorized by the CON program.

Members of the planning staff feel that they have had a part in cutting the growth rate of New York's health care costs. The greatest influence has been on the expansion of access to health facilities through increases in ambulatory and home health care services. They also feel that expansion of inspection teams has improved the quality of service.

In 1976, the Commissioner of Health was granted the power to place reviewers on site to analyze the appropriateness of Medicaid admissions. Independent of the Professional Standards Review Organization (PSRO) program, these reviewers evaluated lengths of stay, appropriateness of surgery, and "deferrable" surgery cases. They also instituted a "second opinion" program in seventy hospitals with a high volume of Medicaid patients, primarily in urban areas. Twenty-five to thirty of these hospitals were in New York City. Although days were denied to hospitals, Medicaid per diems were not to be collected for them, and doctors' fees were not to be paid, some New York City hospitals billed and were paid for uncertified days. The Department of Health is still trying to recoup this money.

In 1979, reviewers are still on site in fifty-four hospitals. However, a Memorandum of Understanding has been drawn up with the PSRO and once it is signed, PSRO personnel will assume the on-site reviewers' duties. Their reviews will be certifiable to Medicaid. The state will then begin a monitoring program to insure that the PSROs are monitoring the weekend admission policy, continued stays, expedited preadmission reviews, the second opinion program for individual practitioners and procedures, ambulatory surgery, one-day preparative stays, and the twenty-day limit.

Although days are denied to hospitals, the costs have been incurred in caring for the patients and remain in the base, as do the denied patient days. Thus, average length of stay increases and penalty reductions in per diems are incurred as well. The hospitals therefore will continue to oppose this program as long as this double-jeopardy situation persists.

By virtue of the fact that both rate review and CON are located in the OHSM and that public commitment to cost containment is so strong, the potential for cooperation between the two programs is great. Yet coordination between these regulatory processes is more of an intention than a reality. According to one planning official, rate setters have been very sensitive to the politics of the process. While there has been no exemptive legislation for Certificate of Need, there have been exceptions made for rate setting (for instance, the Emergency Reimbursement Program). In addition, the state has tried to base need determinations and financial feasibility studies on strict technical analyses that follow stringent criteria. The relatively "political" judgments of the HSAs have not been emphasized and it has been only recently that planners have adopted a "relative need" evaluation methodology.

The planners do recognize the importance of the rate setters in enforcing their CON decisions. However, they would like to see better methodologies worked out for both planning and rate review. They feel that this relationship should be made more explicit. The changes being made organizationally and methodologically in the Planning Division should appease the system participants and give the planners and the reimbursement staff a chance to better coordinate their efforts.

Unions

Organized labor is a very strong and pervasive force in New York City and the state, and the hospital workers' unions are no exception. District 1199 and Local 144, as well as other smaller union groups, have been instrumental in bringing about changes in the reimbursement system over the past ten years, either as an outgrowth of their contract negotiations or as part of their lobbying efforts in Albany.

District 1199 of the National Union of Hospital and Health Care Employees, a division of the RWDSU/AFL-CIO, represents the vast majority of unionized hospital workers in New York City. In metropolitan New York, seventy-five to eighty percent of health care workers belong to a union. Of these, seventy percent (or over 37,000 employees) are represented by 1199. Upstate, the numbers are much smaller; only twenty percent of hospital workers are unionized and 1199 represents half of them.

Depending on the institution involved, 1199 represents anywhere from all workers, except physicians, to only one unit, typically the service workers. In most facilities where 1199 is present, nurses and doctors are the only employees not unionized.

The first 1199 hospital was organized in New York City in 1959. In 1962, labor relations laws changed to allow further unionization, and

several new unions were formed. After the initial push toward unionization, 1199 growth continued at a steady rate until the 1975-76 restrictions in the labor laws were imposed. New membership slacked off for several years until nurses started to join the union in 1977-78. Nurses have traditionally been represented by the New York State Nurses Association and have been content to let their contracts match the negotiated settlements of the union. Of late, more and more nurses have voted to let 1199 represent them directly in their contract negotiations.

The New York State chapter of the AFL-CIO originally opposed the formation of 1199 because its enabling legislation included a no-strike clause and called for binding arbitration. District 1199 is not a member of the state organization, but is a division of the national AFL-CIO. When it comes to opposing or supporting big changes in health care or labor laws, 1199 will work with any and all unions and organizations to advance its position. Such was the case when 1199 opposed the freeze on Medicaid rates in 1976, and when it supported the formation of New York State's Council on Health Care Finance.

District 1199 negotiates its contract with an association of some 63 hospitals in metropolitan New York known as the League of Voluntary Hospitals and Homes. The League was formed in 1967 by a group of sixteen hospitals and nursing homes in response to a need for a more rational approach to the bargaining process. Today, the League not only bargains with 1199 but serves as a coordinating body and resource in negotiating for other unions. The pattern of the League's contract settlements influences union settlements in areas surrounding New York City, as well as many nonunion hospital wage and benefit packages. The League's staff also engages in day-to-day activities in connection with contract interpretation, grievances and arbitrations.

Contracts for 1199 workers cover a two-year period. The League negotiates for all its hospitals with 1199 only. Nurses' contracts are not carried by the League's contract, nor do they all expire at the same time. Contracts for workers in the rest of the state usually follow in tandem with the 1199 settlement in New York City.

District officials feel that their current contract with the League is a reasonable one, but this has not always been the case. Before 1975, wage increases were automatically passed through the reimbursement formula. Neither the hospitals nor the state wanted to be involved in negotiations, so, as wages and benefits increased, the state adjusted per diems upward. In 1976, after the start of the city's financial troubles, negotiations tightened up considerably, and the union concentrated on maintaining relative levels of wages and fringe benefits after inflation. However, wages were reclassified as "nonappealable" to the Department of

Health, and with the financial difficulties of New York, hospitals were not willing to increase employees' salaries. The union struck for binding arbitration but received no increases under the arbitrator's decision.

Wage negotiations in 1978 were very political. When the negotiations broke down in early July of that election year, the Governor and his representatives stepped in to assure the union that the reimbursement funds necessary to finance a 14.5 percent wage increase over the next two years would be available.

The union and the League have been very involved in the state regulatory process, not only in 1973, but since their inception. District 1199 leaders feel that the reimbursement system has not always been fair to hospital workers and that prospective reimbursement makes collective bargaining more difficult by giving the hospital administrators clout in keeping wage increases low and hiring severely limited. They feel that the trend factor is set to reflect increases in the cost of labor without consideration of union demands. Since the labor component is carefully calculated, union officials feel that this has inhibited their ability to negotiate freely. They see prospective reimbursement as being negotiable in nonunionized areas, since workers in these locations will never have their salaries match those of comparable workers elsewhere. Also, they are of the opinion that delays in the appeals system have hurt hospital management, and that the reimbursement system is used unfairly to liquidate and close hospitals.

District 1199 has actively supported several pieces of legislation, most notably the 1978 bill that froze charges and also created the State Council on Health Care Financing. Union leaders felt that there should be a more equitable system across all payors and were concerned about the lack of hospital accountability to the public. The bill, as originally drafted, did not include formation of the Council, but the union put pressure on the legislature to allow them input on some type of wage pass-through system, and formation of the Council was the end result. District 1199 now holds the "union" seat on the Council.

The union has also been very concerned about the state's disclosure of information laws. It sued the state for information prior to enactment of the 1973 disclosure law, and the union has continued to push for better legislation in this area ever since. However, officials feel that information has become more readily available since the creation of the Office of Health Systems Management. The union also supported legislation regarding hospital trustee conflict of interest, but it never passed.

The one area where the union has refused to get involved is that of a hospital rate appeal, being very sensitive to manipulation by the hospitals.

If the hospitals were willing to disclose their books and demonstrate that they were not requesting the additional money for other things, the union might consider testifying at an appeal. However, this has not been the case, and the union has stayed out of the situation entirely.

The League concurs with the union's opinion that bargaining is hampered by the prospective reimbursement system, specifically, that by setting per diems at the beginning of the year, rate reviewers are, in effect, dictating the wages for the hospitals and the unions without allowing for negotiated settlements. Part of the problem could be alleviated by having the rate setters involved in the negotiating process, but neither the League nor 1199 wants this to happen. The League also recognizes the dangers of automatic salary pass-throughs, which remove any restraints on the union's salary demands under the threat of a strike.

The proprietary hospitals in New York City are represented, in large measure, by Local 144. Local 144 represents professional, para- and non-professional workers, but no supervisors or physicians. It is active in the seventeen proprietary hospitals in the city, as well as in twenty-three voluntary hospitals.

Local 144 was first organized in 1957. With the big push toward unionization in 1969, 144 reached its peak enrollment, and the Private Hospital Association of New York City was formed. Three years ago, there were thirty-seven proprietary hospitals in New York City, but twenty of them have since been closed. Many of them had their reimbursement held back because of violations of the health code. As a result, union enrollment has decreased dramatically.

As with 1199, Local 144 negotiates its contract every two years. All proprietary hospitals negotiate together for all unionized workers in their hospitals. The voluntary hospitals negotiate independently, but most contracts are fairly uniform.

The union engages in its negotiations with very specific standards in mind and refuses to bargain wages against other fringe benefits. It is very concerned about raising its workers' earnings to a certain level, and it refuses to compromise on this issue. Despite the union's best efforts over the last three years, employees' wages have not corresponded with cost of living increases, and hiring freezes and firings have occurred. While previous contracts never contained provisions protecting employees' positions, the union is currently trying to incorporate job security clauses into its settlements.

Local 144 does not have the political clout of District 1199, but it will lend its weight to an issue that the union feels is important to its workers. On a day-to-day basis, 144 is competing to organize the same

workers as the other unions, but generally, 144 joins with the others to lobby for or against proposed changes in the reimbursement system.

Health Insurance Association of America

The Health Insurance Association of America (HIAA) represents over 300 insurance companies that provide health insurance protection for an estimated 78 million persons under age sixty-five nationwide. In New York, where Blue Cross and Blue Shield have a virtual monopoly on the private insurance market, HIAA affiliates represent about five percent of the population of New York City. In Rochester and Buffalo, they cover ten percent of the health insurance market, and in Syracuse and Albany the percentage is slightly higher.

HIAA has been concerned about the reimbursement system in New York State since passage of the Cost Containment Act of 1969. As independent insurors, HIAA members have been subject to an unregulated charge structure. Lacking the political clout to act alone, the Association could only wait until other groups became dissatisfied with the system as well. After the rash of Blue Cross terminations in 1977 and 1978, the problems with the system became apparent to the public, and enough bipartisan support was generated to get the charge control legislation signed into law, with HIAA working to push the charge control bill through the legislature.

The legislation was not passed easily; the Governor and others were known to have opposed similar legislation in the past. The current system was a proven administrative system with well-known administrative costs; it may have been arbitrary, but it was manageable. The fact that the vast majority of the state is covered by Blue Cross was a significant political factor. A report was issued stating that if the reimbursement system became charge based, the resultant increases in charges would be anywhere from ten to ninety percent. Blue Cross made this report very visible and tried to stir up support for its position. But after the Blue Cross terminations began, the Governor backed off from his commitment to Blue Cross and agreed to support the new legislation. Support also began to come in from other groups and the measure passed the New York legislature.

HIAA is also currently working toward the institution of a budget review system to replace the current formula system, to be administered by an independent rate-setting commission. The Association points to the experiences in this area in states such as Maryland, Connecticut and Massachusetts to bolster its case. The proposed commission would be staffed by full-time professionals in the Office of Health Systems Management. The staff of OHSM has been trained and has developed the expertise to administer the day-to-day workings of the reimbursement system.

HIAA also supports the creation of a policy review board composed of individuals with special interest or expertise in the health care field in a balanced representation of consumers, providers, and purchasers of health care services. This review board would be authorized to review and approve all regulations governing the hospitals' rates and budgets, to review and recommend approval or disapproval of the operating budget of the commission itself, and to submit an independent annual report to the Governor and the legislature evaluating the performance of the commission and making recommendations for increasing its effectiveness.

HIAA also advocates the formation of commission structures throughout all fifty states. The Association feels it has the evidence to show that prospective budget review is the most effective and equitable long-term solution to the problems of cost increases in the health care sector.

PROGRAM RIGOR, INCENTIVES AND EQUITY

This section discusses three important components of any rate-setting system. The rigor of the system can be assessed (at least subjectively) by considering various components of the system, such as outcome, structure, process, and the overall regulatory and legislative environment surrounding the program. The incentives built into the program are extremely important for assessing how the industry reacts to certain regulatory constraints and the process by which the desired (or undesired) outcomes are the result of the system. Finally, the equity of the system must be assessed, both to the regulators representing the public interest and to the industry. Inequities favorable to either side may inhibit the viability and effectiveness of the regulatory system in the long run.

Program Rigor

Program rigor is subjectively assessed in this section through examination of the program's outcomes, structure, and process, and by the reaction of the regulators to these constraints.

Structure

First, unlike many other states with prospective reimbursement, New York has no independent rate-setting commission; the locus of the rate-setting authority is within the state government. Since the rate-setting agency is located in the New York State Department of Health, it presumably is more sensitive to constraints on Medicaid budgets and the ability of the state to pay. While the proximity of the two agencies may encourage this type of interaction, the New York rate-setting agency is even more directly tied to the availability of Medicaid funds than simple location would indicate. Specific legislation (1975) was enacted stating that the state Director of the Budget could approve rates only if the state had the

ability to pay. In New York's case, therefore, reimbursement methodology and any changes in that methodology are tied directly to the state budget. In a state that has very recently faced severe fiscal problems, this situation alone would tend to increase the rigor and impact of the program.

Moreover, there is no avenue for the hospital industry or its association (other than through its lobbying efforts with the legislature) to directly affect the reimbursement mechanism. Recent (1978) legislation, however, has granted the industry some input into a possible future system through their representation on the Health Financing Council.

Finally, the New York State legislature has been quite supportive of the efforts of rate setters to control the industry. Legislation was early in coming and explicit in the authority it gave to the state Department of Health, and has been continually changed over the years to make the system more rigorous. Without this legislative support, it is doubtful whether the state could have imposed such a constraining system.

Process

The rate-setting process in New York is a formulistic one using historical cost data. There is no budget review and no face-to-face negotiation. The rigor of the New York system and its incorporated incentives to the industry can probably best be seen by focusing on several aspects of the New York process--particularly the components of the formula and the appeals process. First, unlike many prospecive budget review systems, the formula in New York includes only depreciation and interest; thus, capital needs in excess of depreciation are not considered allowable costs.[1] Of course, retrospective, cost-based Medicaid systems and Medicare do not pay capital needs in excess of depreciation, so that, other things being equal, the New York system does not appear more rigorous; however, Blue Cross payment mechanisms and other prospective budget review systems do pay some amount of these capital needs. Therefore, at least relative to these systems, the formula may be more rigorous. Also, unlike other systems, there has been little recognition of capital needs related to increased technology.

The formula also includes several penalties, where excess costs are automatically disallowed from the rate. Chronologically, excess routine costs are disallowed and costs associated with underutilized beds are disallowed. Furthermore, these costs are considered excessive at the mean exactly, so that no margin over the average is granted. When the minimum occupancy criteria were discovered to encourage hospitals to increase length of stay, an excess days penalty was added. Ancillary costs were then screened (again automatically and at the exact average), and education

[1]If the hospital has been granted a Certificate of Need for a new service, however, it may appeal for a rate increase during the year.

costs were cut by ten percent. With these penalties the formula now controls routine cost, ancillary intensity, education, occupancy and length of stay. It would appear that the only uncontrolled area of hospital operations (and an area in which the hospital might manipulate to maximize reimbursement) is admissions, since this variable does not enter the formula. However, strict admission and even surgical procedure constraints were added to Article 28 in 1976 and made even more constraining in 1977, so that, while the rate-setting agency does not monitor admissions, the state Department of Health does. Furthermore, if unnecessary admissions or surgical procedures are performed, Medicaid claims are denied on a retrospective basis.

A third area that can influence the rigor of the system is the allowable inflation rate. The use of industry-specific wage indicators in particular should be noted in any system. In New York, there has been no constant policy over time on this matter; however, the most recent legislative amendments to Part 86 and the adoption of the SHIF program have signaled a movement toward the incorporation of internal industry collective bargaining agreements into the trend factor.

A further indication of rigor is the extent of the patient population covered. With Medicaid and Blue Cross per diems set prospectively and charges limited to state-prescribed percentage increases, essentially all payors except Medicare are covered under the system.

In addition, the movement from a discrete grouping system to cluster analysis on a wide range of variables has removed the ability of a hospital to move to the next highest group by simply manipulating one variable. It should be noted that the more sophisticated cluster analysis should produce more homogeneous groups in terms of product differentiation, but whether this is beneficial to the industry in terms of avoiding a ceiling penalty is unclear.

Finally, there have been two previous evaluations of the effect on outcomes of the New York system. The first, an evaluation of the system in downstate New York,[1] found that the system significantly contained increases in costs per patient day. The second, an evaluation of the system's impact in upstate New York,[2] found a controlling effect on

---

[1]University of Washington, Prospective Reimbursement in Downstate New York and its Impact on Hospitals (Seattle, WA: 1976).

[2]Abt Associates Inc. and Policy Analysis, Inc., Analysis of Prospective Payment Systems for Upstate New York. Final report under Contract No. HEW-OS 74-261 to the Social Security Administration, April 6, 1976.

hospital cost increases that was nearly significant. Of course, the evaluations covered only the early years of the system and were confounded somewhat by the presence of ESP, but the results did suggest that the prospective reimbursement system in New York is controlling costs effectively.

Reaction of Regulatees

Finally, perhaps one of the best indicators of the program's rigor over time has been the inordinate amount of appeals made and the litigation initiated by the hospital industry. With the industry virtually unrepresented in the rate-setting process and the unlikelihood of incorporating industry input, hospitals have had little opportunity other than through the courts to seek relief within the program. Over the life of the program, there have been more than 600 court cases brought against the New York State Department of Health. Furthermore, although courts were initially predisposed toward the industry, the recent nursing home scandal over quality of care and Medicaid fraud and abuse may have swayed opinion in the direction of all health regulators. There is some feeling now, however, that proregulation opinion in the state has hit its peak. Because the state's fiscal pressures have lessened somewhat, and because the most recent regulatory changes are deemed by many to be extremely arbitrary, the state is reexamining its reimbursement methodology, particularly in the area of equity, which is discussed in more detail in the section on system equity.

System Incentives

Since there have been so many changes in the reimbursement methodology over time, it is very difficult to point to one set of incentives that have been in effect over the entire time period. There are, however, some incentives built into the system structure that do apply for all years the program has been in effect.

First, the fact that current-year costs and patient days go into the base for calculating the rate two years ahead results in a set of static rather than dynamic incentives. Under certain circumstances, hospitals may be willing to incur short-run deficits (a static disincentive given the penalty structure) by running up costs in order to have a higher reimbursement rate and revenue flow in the future (a dynamic incentive).

In addition, because there are no savings incentives to efficient hospitals below the group average and there are penalties to hospitals above the group average, there may be an incentive for all hospitals to move toward the group average. There may also be an incentive for hospitals to collude, either actively or tacitly, with the result that both low- and

high-cost hospitals will continue to raise costs, thus raising the group average and reducing the potential size of the penalties.

As mentioned earlier, there have been other incentives in the system, but these have changed over time due to changes in the formula. Since the greatest changes were made in 1976, 1977 and 1978, it is useful to discuss the changes in terms of incentives in effect prior to 1976, 1977 and 1978.

First, because there originally was a ceiling penalty only on routine costs, there was an incentive to shift costs into ancillary, educational and outpatient areas. In addition, since ancillary services are revenue producing, there was an incentive to increase ancillary intensity. In 1976, however, a ceiling penalty was introduced for ancillary costs per discharge, ten percent of intern and resident costs were automatically disallowed, and 1976 rates for outpatients were frozen at the 1975 levels. Since these changes controlled all categories of cost (except depreciation), there was much less of an incentive to shift costs from one to the other.

Second, since the payment unit is the per diem, and because hospitals are penalized for low occupancy, the incentive in effect before 1976 was to increase patient days, either through an increased length of stay or increased admissions.[1] This incentive was somewhat weakened in 1976, when admission screening was introduced for Medicaid patients, and it was eliminated in 1977 with the incorporation of a length of stay penalty into the formula.

There was one change in 1977 that may have affected an incentive set up by the grouping mechanism. Prior to 1977, hospitals were grouped discretely by teaching status, size, type, and location for purposes of applying the ceilings. This type of grouping mechanism provided an incentive to change one of these characteristics slightly, thus enabling the hospital to enter the next highest group and avoid a penalty. In 1977, however, the NYSDH changed its grouping mechanism from discrete groupings to groups formed by cluster analysis and many more variables. This change weakened the ability of hospitals to change groups simply through manipulation of one of the grouping characteristics.

The second major set of changes that occurred in the New York system went into effect in the 1978 rate year. Prior to that year, only Medicaid and Blue Cross reimbursement rates were prospectively controlled. Therefore, there was an incentive for hospitals to decrease the case-mix complexity of PR-covered patients and to decrease, other things being equal, the percentage of PR-covered patients admitted. These incentives, however, were somewhat weakened in 1978, when the charge control bill was passed, controlling

[1]The incentive to increase length of stay is probably stronger than the incentive to increase admissions, since the marginal cost of an additional day is below average cost per day.

the amount by which charges could increase. Since all other patient reimbursement increases were then controlled, there was less of an incentive (although still some) to downshift PR-covered patient case mix and decrease the percentage of PR-covered patients admitted. Table 6 lists by year the kinds of incentives in effect and their relative strengths.

TABLE 6: Relative Strength of System Incentives by Year

Incentive	Relative Strength	Year(s)
Dynamic incentive for cost increases in the short run	Indeterminate	All
Incentive to move costs toward group average	Indeterminate	All
Incentive to collude, so all hospitals' costs (in a group) increase	Indeterminate	All
Shift routine costs to ancillary, teaching and outpatient	Strong None	1970 to 1975 1976 on
Increase ancillary intensity, particularly to non-PR covered patients	Strong Weak	1970 to 1975 1976 on
Increase length of stay	Strong None	1970 to 1975 1976 on
Increase admissions	Moderately strong	1970 to 1975
Reduce routine costs	Strong	All
Shift inpatient costs to outpatient	Weak	1976
Change characteristics to move to higher cost group	Strong	1970 to 1976

System Equity

Extent of Due Process

Until 1977, hospitals had no right to a hearing on the basis of an audit appeal; the appeal was handled administratively, and, if denied, could be appealed to the Rate Review Panel. This panel held an informal review without the hospital's participation. If the appeal was again denied, the only recourse to the hospital was a formal court case.

Given this situation and the large number of appeals brought to court in 1976, the hospitals began to win their various court cases on grounds of lack of due process. As a result, the state adopted procedures for due process for audit appeals in 1977 and for rate appeals in 1978. Thus, full due process was not available to the industry until seven or eight years after the program's inception.

With regard to equity in changing the regulatory process, the industry has fared somewhat better. Since any changes to Part 86 must generally be approved by the Hospital Review and Planning Council, which holds public hearings on the proposed changes, the industry does have the opportunity for some input into the system.

Ambiguity in Rate Setting

Unlike many states whose written budget review legislation is vague in terms of the methodology for setting rates, the New York legislation is quite clear and unambiguous in stating what disallowable costs will be, what penalties will be levied, and for what year the various provisions will be in effect. The Part 86 rules and regulations simply provide more detail on exact methodologies to be used. The only area where the legislation and the rules are not clearly delineated is the trend factor; while the legislation states that area economic factors and collective bargaining agreements will be taken into account, the exact indices to be used are not specified.

Arbitrariness in the Rate-Setting System

The component of the New York system most criticized for arbitrariness is the automatic ceiling disallowances. Until 1976, ceiling limits were set at 110 percent of the peer group averages. Clearly, some cut-off point needs to be specified at which excess costs are considered inefficient, but the appropriateness of 110 percent is questionable. In addition, occupancy penalties may have treated rural hospitals somewhat inequitably since small, rural hospitals need not have many beds underutilized to be hit by an occupancy penalty. Furthermore, closing down beds in a rural area might seriously jeopardize access.

The equity of the 1976 changes (moving the ceiling limit from 110 percent to 100 percent) is even more questionable. At least with the 110 percent ceiling, there was some margin for hospitals to move; with the 100 percent ceiling, there is no room.

Uncertainty in the Rate-Setting System

Uncertainty over changes in rate methodology and the amount of the rates will affect the equity of the system. While changes in the rules are generally known by the industry, there have been extensive delays in the publication of the actual prospective rates. In fact, until 1977, hospitals did not know what their prospective rates would be at the beginning of the year. Furthermore, the extensive backlog of appeals and the delays in decisions in the various lengthy court cases have caused a great deal of uncertainty over what final rates of payment will be.

Equity in Interhospital Comparisons

The grouping mechanism has become more equitable over the years in the New York system, particularly in 1977, when the cluster analysis was adopted and more variables describing the hospitals' service and payor mixes were incorporated. While the grouping mechanism actually does not take case-mix differences into account, the appeals process will consider differences in routine costs, ancillary costs, and length of stay due to complexity of case mix. Finally, wage-geographic differentials are taken into account in applying the ceiling limits, thus adjusting for different labor markets.

Extent of Cross-Subsidization

Until 1978, the New York program controlled only Medicaid and Blue Cross rates. Since Medicare has reimbursed retrospectively according to its reimbursement policies, the potential for cross-subsidization of PR-covered patients by charge-paying patients has been quite large. Hospitals could increase charges to these patients to recover those costs disallowed in the PR reimbursement rates.

This potential for cross-subsidization may also have led to inequities among hospitals, depending on their mix of patients. Hospitals with larger proportions of charge-paying patients may have been able to shift noncovered costs more readily into their charge structure than hospitals serving large indigent populations. There is evidence that several New York City hospitals, on the verge of bankruptcy and serving a large Medicaid and no-pay population (particularly in OPD and emergency), were unable to recoup losses on PR patients through increased charges to their non-PR-covered patients.

APPENDIX A

PERSONS WHO PROVIDED INFORMATION USED IN THIS CASE STUDY

Mr. Bill Abelow
Executive Director
League of Voluntary Hospitals

Mr. George Allen
President
Hospital Association of New York State

Mr. Steve Anderman
Director
Bureau of Hospital Rate Setting
New York State Department of Health

Ms. Judy Berek
Local Union 1199
New York City

Mr. Chet Burrell
Assistant Director
Division of Health Care Financing
New York State Department of Health

Mr. Earl M. Collier
Executive Deputy Director
Office of Health Systems Management

Mr. Steve Cooper
Director of Staff
Health Care Financing Council

Mr. Don Davidoff
Assistant Director
Facility Surveillance Group
New York State Department of Health

Mr. Jack Farmer
Vice President, Reimbursement
Blue Cross/Blue Shield of Greater
New York

Mr. Jack Finn
Director of Capital Cost Engineering
New York State Department of Health

Monsignor Fitzpatrick
Hospital Association of New York State

Dr. Jerome Goldsmith
Committee on Fiscal Policy
Hospital Review and Planning Council

Mr. Jack Herbst
Director
Bureau of Economic Analysis

Ms. Linda Lamel
Deputy Superintendent of Insurance
New York State Insurance Commission

Mr. Bill McCann
Executive Director
Council on Health Care Financing

Mr. Charles Miller
Partner
Covington and Burling

Mr. Lou Orsini
Vice President and Director
Consumer and Professional Relations
Division
Health Insurance Association of America

Mr. Stan Peck
Associate Director
Health Insurance Association of America

Mr. Frank Perez
Vice President, Hospital Division
Service Employees International Union

Mr. Bob Reed
Administrative Services Group
New York State Department of Health

Dr. John Rossman
Director of Health Economics
Hospital Association of New York State

Ms. Carolyn Scanlon
Director
Bureau of Hospital Services
New York State Department of Health

Mr. Steven Steinhardt
Assistant Counsel
Health Care Financing

Mr. Lee Vandecarr
Director
Administrative Services Group
New York State Department of Health

Mr. Phil Valenti
Senior Analyst
Provider Reimbursement
Blue Cross of Northeastern
New York, Inc.

Mr. Art Webb
Executive Director
Health Planning Commission
New York State Department of Health

Mr. John Zampier
Director of Provider Reimbursement
Blue Cross of Northeastern
New York, Inc.

Health Care Financing Grants and Contracts Reports

U.S. Department of Health, Education, and Welfare
Patricia Roberts Harris, **Secretary**

Health Care Financing Administration
Leonard D. Schaeffer, **Administrator**

Office of Research, Demonstrations, and Statistics
James M. Kaple, **Acting Director**

Diane Bolay, **Director, Program Planning and Support**

Karen Pelham O'Steen, **Research Publications Coordinator**
Cynthia Dingle, **Editorial Assistant**

The statements and data contained in this report are solely those of the contractor or grantee and do not express any official opinion of or endorsement by the Health Care Financing Administration.

Send changes of address or requests for this publication to: ORDS Publications, Rm 1E9 Oak Meadows Building, 6340 Security Blvd., Baltimore, MD 21235.

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
BALTIMORE, MARYLAND 21235

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE, $300

POSTAGE AND FEES PAID
U S DEPARTMENT OF H E W
HEW-397

U.S.MAIL

CMS LIBRARY
3 8095 00012160 4

U.S. Department of
Health, Education, and Welfare
Health Care Financing Administration
HEW Publication
HCFA Pub. No. 80-03035